CARRIER

Sedgwick PO Box 14497 Lexington, KY 40512-4497

1500

HEALTH INSURANCE CLAIM FORM

PICA		PICA
. MEDICARE MEDICAID TRICARE CHAM	HEALTH PLAN BLK LUNG	THER 1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Member	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(D) 464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #8976
PATIENT'S ADDRESS (No Street)		_
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
STATE		¬ · · · · · · · · · · · · · · · · · ·
DESOTO TX	Single Married Other	ZP CODE TELEPHONE (INCLUDE AREA CODE)
P CODE TELEPHONE (Include Area Code) 75115 972 230 4230	Full-Time Part-Time	751461874 912 223-4929
312 230-4230	Employed Student Student	11, INSUREDS POLICY GROUP OR FECA NUMBER
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) N / A	10. PATIENT'S CONDITION RELATED TO:	200805265690001NE
OTHER INSURED'S POLICY OR GROUP NUMBER		
	a, EMPLOYMENT? (CURRENT OR PREVIOUS)	MM ; DD ; W
N / A OTHER INSURED'S DATE OF BIRTH SEX	h AUTO ACCIDENTS	b. EMPLOYER'S NAME OR SCHOOL NAME
MM ; DO ; YY		N/A
N / A: M F F F F F F F F F F F F F F F F F F		c. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	c. OTHER ACCIDENT?	N / A
INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of a I also request payment of government benefits either to myself or to the party who 	y medical or other information necessary to process this cl accepts assignment below	aim. benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM 00 YY INJURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DO : YY 05: 22 2008	FROM N A A TO N A A
	7a. 34 54 54 64 64	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
	75 NPI	FROM N / A TO N / A
. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY UNE)	22. MEDICALD RESUBMISSION ORIGINAL REF. NO.
11 724.4	3. 847.2	N/A
	₩	23. PRIOR AUTHORIZATION NUMBER
2 844.9	4.	N / A
4. A DATE(S) OF SERVICE B C	D	F G H I
FROM TO of (EDURES, SERVICES OR SUPPLIES Explain Unusual Circumstances) DIAGNO POINT	
	213 MODIFIER POINT	97.74 1 OB MDK1590T
Level 3 Return Expanded Vis	it	1 1 NP 183121965
06 27 09 Carrier/Insurance		-86 ⁰¹
		NPI
03 24 09 03 24 09 11 99 Required report charge/DWC	080 73 2,	3 15.00 1 0B MDK1590T
Required report charge/DWC	/3	NP 183121965
		NPF NPF
		I NPI
	1 1 1 1	l NPI
5. FEDERAL TAX I.D. NUMBER 26. PATIENT'S A	COUNT NO. 27 ACCEPT ASSIGNMENT	
SSN DIN	23460941 (For govt. claims, see back	112.74 -86.01 , 26.7
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND A	DDRESS OF FACILITY WHERE SERVICES WERE	33 PHYSICIANS SUPPLIERS BILLING NAME ADDRESS ZIP CODE
(I certify that the statements on the reverse apply to this	other than home or office) DFW Med Center	u.s. MedGroup, P.A. (800)733-7098
Conce	tra Medical Centers	PO Box 865
,	Ilmbrook Dr Ste 101	Addison, TX 75001-9005
Ranil R Ninala, MD	TX 75247	- 1652 - 22
02/24/2010 DATE 16795		*1184810152 *MDK1590TX
IUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS-1500 (08

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HEALTH INSURANCE CLAIM FORM

PICA		CONTROVERS IN ITEM ()
MEDICARE MEDICAID TRICARE CHAMPI	HEALTH PLAN BLK LUNG	1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member	<u></u>	464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	9. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #8976
. PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
YTK YTK	8. PATIENT STATUS	CITY
DESOTO	Single Married Other	Lancaster TX
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Full-Time Part-Time Student Student	751461874 912 223-4929
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N / A		200805265690001NE
B. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
	X YES NO	N/A M
N / A b. OTHER INSURED'S DATE OF BIRTH SEX	- Lump Accipes III	b. EMPLOYER'S NAME OR SCHOOL NAME
MM : DO : YY	r Dace (State)	N/A
N / A M F		c, INSURANCE PLAN NAME OR PROGRAM NAME
G. EMPLOYERS NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	N/A
N / A	YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
d, INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE 200805265690001NE	
N / A		
READ BACK OF FORM BEFORE COMPLETING & SIGN 12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE. I authorize the release of an	medical or other information necessary to process this claim.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
I also request payment of government benefits either to myself or to the party who a	ccepts assignment below	
armine ou stre	N / 2	SIGNATURE ON FILE
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNATURE ON 1112
	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM; DO; YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM , DD ; YY MM , DD ; YY
05 22 2008 INJURY (ACCIDENT) OR PREGNANCY (LMP)	05 22 2008	FROM N / A TO N / A
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	8. (44.) (14.)	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
Ţī	7b NPI	FROM N / A TO N / A
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITE	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,5 OR 4 TO ITEM 24E BY LINE)	
. 1 724.4	s. 844.9	N/A
1. 762.3	4	23. PRIOR AUTHORIZATION NUMBER
21 847.2	4.1	N/A
		F I G I H I J
24. A DATE(S) OF SERVICE B C PROCE	D E DURES, SERVICES OR SUPPLIES	I DAYS I EPSOT ID. RENDERING
FROM TO of (E	plain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	\$ CHARGES OR Farrity QUAL PROVIDER ID. #
05:04-09:05:04:09:11: 1 99	080 ₁ 73 ₁ 2,3	15.00 1 OB MDK1590TX
Required report charge/DWC	73	1831219658
07 30 09 Carrier/Insurance	- Payment	0.00
		NPI
•• • • • • • • • • • • • • • • • • •	214 3	
Level 4 Return Complex Visi		NP 1831219658
07 30 09 Carrier/Insurance	- Payment	0.00
08 05 09 Carrier/Insurance	- Payment	-129, 27, I NPI
	\$\langle \text{\$\frac{1}{8}\cdot\$}	
		I NPI
		NF4
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	COUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
SSN CIV	23460941 YES NO	s 161:90 s -129:27 s 32:63
31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32, NAME AND A	DDRESS OF FACILITY WHERE SERVICES WERE	AN PROPOSANTE SURGILERS BILLING NAME ADDRESS 7/R CODE
INCLUDING DEGREES OR CREDENTALS (I) certify that the statements on the reverse apply to this	other than home or office)	U.S. MedGroup, P.A. (800) 733-7098
hit and are made a part thereof.)	DFW Med Center tra Medical Centers	PO Box 865
8267 Elmbrook Dr Ste 101 Addison, TX 75001-9005		
Ranil R Ninala, MD	my 75247	
02/24/2010 Dallas	75247	*1184810152 * MDK1590TX
NICC leatrestics Manual available at wave pucc ord		APPROVED OMB-0938-0999 FORM CMS-1500 (08/0

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HEALTH INSURANCE CLAIM FORM

-CARRIER

PICA			PICA
MEDICARE MEDICAID TRICARE CHAMPA	/A GROUP FECA OTHER	1A. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member		464-88-5121	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle	Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #8976	
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35	E
STATE STATE	8. PATIENT STATUS	CITY	STATE TX CHE (INCLUDE AREA CODE) 12 223-4929 SEX M F
DESOTO	Single Married Other	Lancaster	TX
TELEPHONE (Include Area Code)		ZIP CODE TELEPHO	ONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Full-Time Part-Time Student Student	751461874 9	12 223-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
N / A		200805265690001NE	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH	SEX
N / A	X YES NO	NM DD YY	M F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
MM / DD YY	YES NO	N / A	
EMPLOYERS NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
N / A	YES NO	N / A	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
N / A	200805265690001NE	YES NO IFYES, I	return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN		13. INSURED'S OR AUTHORIZED PERSON'S SIGNAT	URE I authorize payment of medical
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of an I also request payment of government benefits either to myself or to the party who a	y medical or other information necessary to process this claim.	benefits to the undersigned physician or supplie	T IN SOLAINOS SOSCIIDOS DOLVAS.
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNATURE	ON FILE
A DATE OF CURRENT ILLNESS (FIRST SYMPTOM) OR 15	IF PATIENT HAS HAD SAME OR SIMILAR ILLINESS,	16. DATES PATIENT UNABLE TO WORK IN CURREN	T OCCUPATION
MM : DD : YY O5: 22 : 2008 INLIRY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY 05 22 2008	FROM N A DD YY TO	N / A
7. NAME OF REPERPING PHYSICIAN OR OTHER SOURCE 17		18. HOSPITALIZATION DATES RELATED TO CURREN	NT SERVICES
7	7b NPI	FROM N / A TO	
9. RESERVED FOR LOCAL USE			ARGES
Janet DuPertuis		YES NO	
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITE	EM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL	REF. NO.
1 724.4	3.1 844.9	N/A	N / A
1	→	23. PRIOR AUTHORIZATION NUMBER	
21 847.2	4.	N / A	
	D E	FGH	1 1
Place PROCE	EDURES, SERVICES OR SUPPLIES	L COMPOSE OF FAMILY 1	D. RENDERING
MM DD YYYY MM DD YYYY Service EMG CPT/HCP	CS MODIFIER POINTER	UNITS Plan	
	080 73 2 2,3	15.00 1 0	1831219658
Required report charge/DWC	214	159.23 1 0	B MDK1590TX
06 01 09 06 01 09 11 99 Level 4 Return Complex Visi		1 100,110 1	1831219658
07 28 09 Carrier/Insurance		-135.69	B MDK1590TX 1831219658
01 50 03 Carrier, Lushrance	Taxing		NPI
		·	NPI
5 2 2			
			NPI
			NPI
25. FEDERAL TAX I.D. NUMBER SSN. EIN 26. PATIENT'S AC	COUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGES 29. AMOUNT.	PAID 30 BALANCE DUE
330	23460941 YES NO	174.231	35 69 - 38 54
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND A	DORESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, AD	
INCLUDING DEGREES OR CREDRINTALS RENDERED (If	other than home or office) DFW Med Center	U.S. MedGroup, P.A	
Concer	tra Medical Centers	PO Box 865	
· •	lmbrook Dr Ste 101	Addison, TX 75001-	-
Ranil R Ninala, MD	TX 75247		
02/24/2010 DATE 167950		*1184810152	MDK1590TX
SIGNED 02/24/2010 167950	4831	*1184810152	MDK1590TX

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HEALTH INSURANCE CLAIM FORM

PICA				PICA
	CHAMPVA GROUP FECA HEALTH PLAN BLK LUNG	OTHER		(FOR PROGRAM IN ITEM 1)
	Member ID#) ((SSN or ID) (SSN)	X (ID)	464-88-5121	
: PATIENT'S NAME (Last Name, First Name, Middle initial)	MM DD YY	EX	4. INSURED'S NAME (Last Name, First Name	e, Middle Initial)
Evans, Melvin	05 17 1950 M X	F	Home Depot #897	6
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child	Other	500 N Interstate	e 35 E
YIK	STATE 8. PATIENT STATUS		any	STATE
DESOTO	Single Married O	ther	Lancaster	TX
ZP CODE TELEPHONE (Include Area Code)	Full-Time Part	Time [ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Stud		751461874	912 223-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA N	LMBCR
N / A	· · · · · · · · · · · · · · · · · · ·		20080526569000	INE
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSUREDS DATE OF BIRTH MM DD YY	SEX _
N / A	X YES NO		N A b. EMPLOYERS NAME OR SCHOOL NAME	м
DO THER INSURED'S DATE OF BIRTH SEX		LACE (State)		· · · · · · · · · · · · · · · · · · ·
N/A M F	YES NO		N / A c. INSURANCE PLAN NAME OR PROGRAM	NAME
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?		N / A	STATE TX TELEPHONE (INCLUDE AREA COOE) 912 223-4929 LAMBER 1NE SEX M F
N / A	10d, RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT I	
, INSURANCE PLAN NAME OR PROGRAM NAME	20080526569000:	1 NE	YES NO	If YES, return to and complete items 9a-d.
N / A READ BACK OF FORM BEFORE COMPLETING				S SIGNATURE I authorize payment of medical
12 PATIENTS OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release	se of any medical or other information necessary to proceed	se this claim.	benefits to the undersigned physician	or supplier for services described below.
I also request payment of government benefits either to myself or to the par	у ило ассорта авадителя веюм	-		
SIGNATURE ON FILE	DATE N / A		SIGNED SIGNATU	URE ON FILE
3042				CHARGE TO COCK BATION
4 DATE OF CURPENT MM ; DD ; YY NULLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR INJURY (ACCIDENT) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNES , GIVE FIRST DATE MM ; DD ; YY 05; 22; 200		16. DATES PATIENT UNABLE TO WORK IN	TO N / A
05: 22:2008 PREGNANCY (LMP) 7. NAME OF REPERRING PHYSICIAN OR OTHER SOURCE	05; 22 (200	195	18. HOSPITALIZATION DATES RELATED TO	CURRENT SERVICES
	17b NPI		FROM NI / A	TO N / A
9. RESERVED FOR LOCAL USE			20. OUTSIDE LAB?	\$ CHARGES
Janet DuPertuis			YES NO	
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR	TO ITEM 24E BY LINE)	1	22. MEDICAID RESUBMISSION	ONICIONAL DEE NO
	s.I 844.9		CODE N / A	ORIGINAL REF. NO. N / A
1. 724.4		ϕ	23, PRIOR AUTHORIZATION NUMBER	
21 847.2	4.)		N / A	
	D	E	F G	H 1 7 J
Place Place	PROCEDURES, SERVICES OR SUPPLIES	DIAGNOSIS	DAYS I EP	mily secure to a
MM DD YYYY MM DD YYYY Service EMG C	(Explain Unusual Circumstances) PT/HCPCS MODIFIER	POINTER	17.25 1	OB MDK1590TX
06, 30, 09, 11, 09, 11, 09, 11, 09, 11, 09, 11, 09, 09, 11, 09, 09, 11, 09, 09, 11, 09, 09, 09, 09, 09, 09, 09, 09, 09, 09	99080 73	2,3	TARREST TARREST	1831219658
Required report charge/DW 06 30 09 06 30 09 11	99213	2	105.71 1	OB MDK1590TX
Level 3 Return Expanded \				NFI 1831219658
08 05 09 Carrier/Insurance		4.5	-90:.08	
				NPI
THE RESERVE OF THE PARTY OF THE	890 N. 118	/:		8
<u> </u>			1 1 1	NPI
				NPI
		•		ļļ
			-	NPI
SSN EIN	VT'S ACCOUNT NO. 27.ACCEPT ASSIC	ee back)	· · · · · · · · · · · · · · · · · · ·	AMOUNT PAID
	-0023460941 YES	NO CON	\$ 122.96 \$	-90 08 32 88
INCLUDING DEGREES OR CREDRITALS RENDE	AND ADDRESS OF FACILITY WHERE SERVICES WERE RED (If other than home or office)		33. PHYSICIANS, SUPPLIERS BILLING N & PHONE #.	(800) 733-7098
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	- DFW Med Center	_	U.S. MedGroup, PO Box 865	P.A.
	centra Medical Centers 7 Elmbrook Dr Ste 101	5	Addison, TX 750	01-9005
Denil D Winels MD	•			
02/24/2010 LDAL	las, TX 75247 9504831	196	-1184810152	^b MDK1590TX
SIGNED DATE 167	33V4631	2 <u>8</u> 46:	110401030	MDRID9012

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HEALTH INSURANCE CLAIM FORM

CARRIER

PICA		PICA (┸
MEDICARE MEDICARD TRICARE CHAMPUS CHAMPUS	HEALTH PLAN BLK LUNG		1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	(SSN or ID) (SSN) X (ID)	464-88-5121	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Evans, Melvin	05 17 1950 M X F	Home Depot #8976	
5. PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Setf Spouse Child Other	500 N Interstate 35 E	;
CITY STATE	B. PATIENT STATUS	CITY	
DESOTO TX	Single Married Other	Lancaster TX	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
75115 972 230-4230	Employed Full-Time Part-Time Student Student	751461874 912 223-4929	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	1
N / A		200805265690001NE	;
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX	
N / A	X YES NO	N A Y	
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYERS NAME OR SCHOOL NAME	
N A	YES NO	N / A	
c. EMPLOYER'S NAME OR SCHOOL NAME	c OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
N / A	YES NO	n / A	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.	.
READ BACK OF FORM BEFORE COMPLETING & SIGN	ING THIS FORM	13. INSUREDS OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of media	ical
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of at I also request payment of government benefits either to myself or to the party who	ny medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.	
I also request payment or government periodic autres to myself or to bring and	and the same of th		
SIGNED SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE]
	S. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
14 DATE OF CURRENT MM : DD : YY 05: 22 2008 ILLNESS (FIRST SYMPTOM) OR INLIRY (ACCIDENT) OR PREGNANCY (LMP)	GIVE HIRST DATE MM DD YY 05 22 2008	FROM NY / 20 YY TO NY / 2	7
	78.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERMCES	
 	17b NPI	FROM NY A TO N A	
19. RESERVED FOR LOCAL USE	1 1	20. OUTSIDE LAB? \$ CHARGES	
Janet DuPertuis		TYES TNO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,9 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION	$\overline{}$
	3.1 844.9	CODE N / A ORIGINAL REF. NO. N / A	
1. 724.4	J	23. PRIOR AUTHORIZATION NUMBER	$\neg \neg$
21 847.2	41	N/A	
	•		
24. A DATE(S) OF SERVICE B C	D E EDURES, SERVICES OR SUPPLIES	F G H I J	, POTX
	TVACUTOR -	\$ CHARGES OR Family QUAL PROVIDER ID.)
09:11:09:09:11:09:11: 99	080 ₁ 73; 2,3	17.25 1 0B MDK159	XTQ
Required report charge/DWC	73	1831219	
01 12 10 Carrier/Insurance	- Payment	0.00	
		NP NP NP F	90TX
)213 3	105.71 1 0B MDK159	AUTX
Level 3 Return Expanded Vis		1031213	2028
01 12 10 Carrier/Insurance	- Payment	0.00	
		NP)	
		1 N ²	
	27.ACCEPT ASSIGNMENT?	NPI SO DA MASS CO	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AI	(For govt. daims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DL	Age against
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	23460941 YES NO		22.96
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDRITALS 32. NAME AND A RENDERED (II	DDRESS OF FACILITY WHERE SERVICES WERE ather than home or office)	33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #. (800) 733-70	98
	DFW Med Center	U.S. MedGroup, P.A. PO Box 865	
	ntra Medical Centers Elmbrook Dr Ste 101	Addison, TX 75001-9005	İ
Danil P Winels MD	,		
02/24/2010 Dallas	75247 74831	*1184810152 *MDK1590TX	
SIGNED 02/24/DATE 16795	74831	*1184810152 MDK1590TX	

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HEALTH INSURANCE CLAIM FORM

PICA			PICA
. MEDICARE MEDICAID TRICARE CHAMPUS	HEALTH PLAN BLKLUNG	1A INSURED S.D. NUMBER 464-88-5121	(FOR PROGRAM IN ITEM 1)
(Medicare if) (Medicaid if) (Sponsor's SSN) (Membe		4. INSURED'S NAME (Last Name, First Name, Middle	Lisan
. PATIENT'S NAME (Last Name, First Name, Middle Initial) Evans, Melvin	3. PATIENT'S BIRTH DATE SEX SEX OF THE SEX SEX SEX SEX SEX SEX SEX SEX SEX SE	Home Depot #8976	iritea)
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35	i E
OTY STATE	9. PATIENT STATUS	ату	STATE
DESOTO TX	Single Married Other	Lancaster	TX
ZP CODE TELEPHONE (Include Area Code)	-	ZIP CODE TELEPHO	ONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student	751461874 9:	12 223-4929
D. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
n / A		200805265690001NE	·
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH	SEX
N / A	X YES NO	NM DD YY	M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
MM / 00 YY M F	YES NO	N / A	!
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	STATE TX CHE (INCLUDE AREA CODE) 12 223-4929 SEX M F
N / A	YES NO	N/A	
II. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
N / A	200805265690001NE		elum to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an	w medical or other information necessary to process this claim.	 INSURED'S OR AUTHORIZED PERSON'S SIGNAT benefits to the undersigned physician or supplied 	URE I authorize payment of medical r for services described below.
I also request payment of government benefits either to myself or to the party who	accepts assignment below.		
SIGNATURE ON FILE	DATE N / A	SIGNATURE	ON FILE
		SIGNED	
MM : DO : YY INBURY (ACCIDENT) OR	F PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 05, 22, 2008	16. DATES PATIENT UNABLE TO WORK IN CURRENT	MM ; DD ; YY
05 22 2008 PREGNANCY (LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 11.	7a. 15, 22, 2008	18. HOSPITALIZATION DATES RELATED TO CURREN	N / : A :
[7]	75 NPI	FROM N / A I YY	N / A · Y
9. RESERVED FOR LOCAL USE			ARGES
Janet DuPertuis		YES NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION OFIGINAL	REF. NO.
, 724.4	s <u>844.9</u>	N/A	N / A
	₩	23. PRIOR AUTHORIZATION NUMBER	
2 847.2	4.	N / A	
24. A DATE(S) OF SERVICE B C	D E	F G H DAYS EPSDT	D. RENDERING PROVIDER ID. #
FROM TO of SMG (E	EDURES, SERVICES OR SUPPLIES Explain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	a cuancine OP Family	D, RENDERING UAL PROVIDER ID. #
	080 73 2,3	17.25 1 O	B MDK1590TX
Required report charge/DWC	73	· · · · · · · · · · · · · · · · · · ·	1831219658
10 06 09 10 06 09 11 99	214 3	159.23 1 0	B MDK1590TX
<u> Level 4 Return Complex Visi</u>			<u>1831219658</u>
	1 : : : * *		
			(A)
		2.67	
			B MDK1590TX # 1831219658
		!	NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	COUNT NO. 27 ACCEPT ASSIGNMENT? (For govi. daims, see back)	28. TOTAL CHARGES 29, AMOUNT F	
752612924 X I01-00	23460941 YES NO	s 176.48 s	0.00 , 176.48
INCLUDING DEGREES OR CREDRITALS RENDERED (If	ODRESS OF FACILITY WHERE SERVICES WERE other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADD & PHONE #.	(800)733-7098
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	DFW Med Center	U.S. MedGroup, P.A.	
	tra Medical Centers Imbrook Dr Ste 101	PO Box 865 Addison, TX 75001-9	9005
Ranil R Ninala, MD			
02/24/2010 Dallas		*1184810152	MDK1590TX
SIGNED DATE 167950	4831 485 (48)		MDK15901X

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HEALTH INSURANCE CLAIM FORM

PICA	<u></u>		PICA
. MEDICARE MEDICAID TRICARE CHAMFUS	HEALTH PLAN BLK LUNG		(FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member	or ID/f) ((SSN or ID) (SSN) X (1 202 00 0222	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name	ne, Middle Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #897	76
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child Other	500 N Interstat	
STATE STATE	8. PATIENT'STATUS	ату	STATE
DESOTO TX	Single Married Other	Lancaster	TX
P CODE TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Full-Time Part-Time Student Student	751461874	912 223-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA	NUMBER
N / A		20080526569000	DINE
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM : DO : YY	SEX
N / A	X YES NO	N / A	M F
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (Sta	b. EMPLOYER'S NAME OR SCHOOL NAM	=
N / A N F	YES NO	N / A	·
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM	NAME
N / A	YES NO	N/A	-
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT	PLAN?
N / A	200805265690001NE	YES NO	If YES, return to and complete items 9a-d.
READ BACK OF PORM BEFORE COMPLETING & SIGN			IS SIGNATURE I authorize payment of medical or supplier for services described below.
12. PATIENT'S OR AUTHORIZED PERSONS SIGNATURE. I authorize the release of all also request payment of government benefits either to myself or to the party who	ny madical or other information necessary to process this dai accepts assignment below	and the transfer of historia	
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNAT	URE ON FILE
	S. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK II	CURRENT OCCUPATION
05 22 2008 INJURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY 05 22 2008	FROM NM/ A YY	TO N / A W
NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	7a.	18. HOSPITALIZATION DATES RELATED T	O CURRENT SERVICES MM DD YY
	17b NPS	FROM N / A	TO N / A
D. RESERVED FOR LOCAL USE		20, OUTSIDE LAB?	\$ CHARGES
Janet DuPertuis		YES NO	
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE	ORIGINAL REF. NO.
. 847.2	3.	N/A	N / A
·· L		23. PRIOR AUTHORIZATION NUMBER	
2 922.2	4.	N / A	
24. A DATE(S) OF SERVICE B C	D E	FG	H I J
FROM TO PROCE	EDURES, SERVICES OR SUPPLIES Explain Unusual Circumstances) DIAGNOS	DAYS IE	antiv consecutive
MM DD YYYY MM DD YYYY Service I EMS I CPT/HCF	204 ₁ MODIFIER POINTER 1,2	226.68 1	OB MDG1558TX
Level 4 New Complex Visit	204	220.00 1	NP 1548389489
09 05 08 Carrier/Instrance	- Payment	0.00	1340303403
09 05 08 Carrier/Insurance	- Payment	-192.41	NPI
			NEPI
		\$ 70	
			NPI
* 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 1	
			NPI
			NPI
5. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	COUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. daims, see back)	28. TOTAL CHARGES 29.	AMOUNT PAID . 30. BALANCE DUE
to the control of the	23460941 YES NO	\$ 226.68 \$	-192 41 \$ 34 27
	DDRESS OF FACILITY WHERE SERVICES WERE other than home or office)	33. PHYSICIANS, SUPPLIERS BILLING	NAME, ADDRESS, ZIP CODE
If cartify that the statements on the reverse apply to this	DFW Redbird	Occupational He	(800)733-7098 ealth Centers
Concer	tra Medical Centers	of the Southwes	
l i i	Westmoreland Ste 200	PO Box 9005 Addison, TX 750	001-9005
Robert J Stuart, MD Dallas	TX 75237	AMALOUI, IA /J	
02/24/2010 DATE 158869		*1003955220	MDG1558TX
II IOO Instruction Manual qualitable at account account		ADDDOVED OUD	0000 0000 FORM CNC 4500 (00/00

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HEALTH INSURANCE CLAIM FORM

PICA		PICA
. MEDICARE MEDICAID TRICARE CHAM	VA GROUP FECA OTHER	1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Memb	100 LOOM - 100 LOOM - 100 LOOM	464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	S. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 MX F	Home Depot #8976
, PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
STATI	8. PATIENT STATUS	CITY STATE
DESOTO TX	Single Married Other	Lancaster TX
TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
	Full-Time Part-Time	751461874 912 223-4929
3/2 2JV 42JV	Employed Student Student	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	200805265690001NE
N / A		20080528309000TRE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N / A	X YES NO	N/A M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
N/A M F	YES NO	N / A
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	Lancaster TX ZP CODE TELEPHONE (INCLUDE AREA CODE) 751461874 912 223-4929 11. INSUREDS POLICY GROUP OR FECA NUMBER 200805265690001NE a. INSUREDS DATE OF BIRTH MM
n / A	YES NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIG	ING THIS FORM	13. INSUREDS OR AUTHORIZED PERSONS SIGNATURE 1 authorize payment of medical
. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of a I also request payment of government benefits either to myself or to the party who	ny medical or other information necessary to process this claim. accepts assignment below	benefits to the undersigned physician or supplier for services described below.
- mon radional holisous as Septembers accioning again, or side and a side has it uses	• •	
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNATURE ON FILE
	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM ; DD ; YY INJURY (ACCIDENT) OR	GIVE FIRST DATE MM DD YY	MM, DO YY TO MM DO YY
05: 22:2008 PREGNANCY (LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	05 22 2008 7a.	18. HOSPITALIZATION DATES RELATED TO CUPRENT SERVICES
		FROM _ / _ YY MM _ DD _ YY
	17b NPI	N/A N/A
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO I	TEM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE N / A ORIGINAL REF. NO. N / A
, 847.2	s	24 / 25
·· L	─	23. PRIOR AUTHORIZATION NUMBER
2 922.2	4.	N/A
24. A DATES DESCRIPTION B C	D E	F G H I DAYS I EPSDT ID. RENDERING PROVIDER ID. 18.73 1 OB PT1148030TX
Place I I PRO	DEDURES, SERVICES OR SUPPLIES Explain Unuqual Circumstances) DIAGNOSIS	DAYS EPSDT ID. RENDERING S CHARGES DR Family CHARGES PROVIDER ID. #
MAM DD YYYY MM DD YYYY Service I EMAG I CPT/HC	PCS MODIFIER POINTER	18:73 1 OR PTI148030TX
	0283	18 73 1 0B PT1148030TX
Electrical Stimulation Unat		1 1295923322
09 05 08 Carrier/Insurance	- Payment	-15.34
		· · · · · · · · · · · · · · · · · · ·
•••• •= ••• ••• •= • • ••	7110, 1	46.21 1 0B PT1148030TX
Therapeutic Exercises-15m		1293923322
09 05 08 Carrier/Insurance	- Payment	-37.51
	7001 50	124: 93 1 0B PT1148030TX
	7001 59 1,2	
PT Eval		
09 05 08 Carrier/Insurance	- Payment	-95: 60
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	CCOUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
I was to the same of the same)23460941 YES NO	s 189.87 s -148.45 s 41.42
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND	ODRESS OF FACILITY WHERE SERVICES WERE	33, PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #. (800) 733-7098
(I certify that the statements on the reverse apply to this	other than home or office) DFW Redbird	Occupational Health Centers
bill and are made a part thereof.)	ntra Medical Centers	of the Southwest, P.A.
	Westmoreland Ste 200	PO Box 9005
Brent M Davis, PT	s, TX 75237	Addison, TX 75001-9005
02/24/2010 DATE 15886		*1003955220 PT1148030TX
ORDER 13880		1003933225

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HEALTH INSURANCE CLAIM FORM

PICA		PICA L
MEDICARE MEDICAID TRICARE CHAMPUS	HEALTH PLAN BLK LUNG (
(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
PATIENTS NAME (Last Name, First Name, Middle Initial) Evans, Melvin	3. PATIENT'S BIRTH DATE SEX 90 NO X F	Home Depot #8976
PATIENTS ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr	Sett Spouse Child Other	500 N Interstate 35 E
STATE YTE	8. PATIENT STATUS	CITY STATE
DESOTO	Single Married Other	Lancaster TX
IP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student	751461874 912 223-4929
). OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	CITY Lancaster TX ZP CODE 751461874 912 223-4929 11. INSUREDS POLICY GROUP OR FECA NUMBER 200805265690001NE a. INSUREDS DATE OF BIRTH MM ; DD ; YY N / A
N / A LOTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N / A	a. EMPLOYMENT? (CORPENT OF PREVIOUS)	a INSURED'S DATE OF BIRTH SEX MM DD YY N A F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYERS NAME OR SCHOOL NAME
N / A	YES NO	N / A
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	YES NO	
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an	y medical or other information necessary to process this claim.	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
I also request payment of government benefits either to myself or to the party who	accepts assignment below	
SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
	, IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16 DATES PATIENT LINABLE TO WORK IN CURRENT OCCUPATION
4 DATE OF CLIFFIENT MM ; DO ; YY MM ; DO ; Y	GIVE FIRST DATE MM DD YY 05: 22 2008	FROM N / A TO N / A
	7a. 1	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
<u>[</u>	7b NPI	FROM N / A TO N / A
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO. N / A
1 847.2	3	23. PRIOR AUTHORIZATION NUMBER
21 922.2	41	N/A
	D E	F G H I J
DATE(S) OF SERVICE Place PROC	EDURES, SERVICES OR SUPPLIES Explain Unusual Circumstances) DIAGNOSIS	DAYS EPSDT ID. RENDERING
MM DD YYYY MM DO YYYY! Service EMG CPT/HCF	CS MODIFIER POINTER	, 49.43 1 0B PT1148030TX
06:03:08:06:03:08:11: 97 Self Care/Hm Mgt Training-1	333	1295923522
09 05 08 Carrier/Insurance	- Payment	1 -40.17
		NPI NPI
		+ + +
		NPI
		l l NP!
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	[For govr. claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
	23460941 YES NO	\$ 49.43 \$ -40.17 \$ 9.26 33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE
INCLUDING DEGREES OR CREDRITALS RENDERED (II	DDRESS OF FACILITY WHERE SERVICES WERE other than home or office)	a PHONE N. (800) 733-7098 Occupational Health Centers
hill and are made a part thereof)	DFW Redbird ntra Medical Centers	of the Southwest, P.A.
	Westmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
Brent M Davis, PT	s, TX 75237	
SIGNED 02/24/2010 13113		*1003955220 PT1148030TX

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HEALTH INSURANCE CLAIM FORM

PICA		PICA
MEDICARE MEDICAID TRICARE CHAMPUS CHAMPUS	HEALTH PLAN BLK LUNG	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	<u></u>	464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Lest Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #8976
PATIENT'S ADORESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
TY STATE	8, PATIENT STATUS	CITY
DESOTO TX	Single Married Other	Lancaster TX
P CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student	751461874 912 223-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	200805265690001NE
N / A	-	
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	A. INSURED'S DATE OF BIRTH MM DD YY NY D Y
N / A OTHER INSURED'S DATE OF BIRTH SEX	b, AUTO ACCIDENT?	N A M
WW ; DD ; YY	PLACE (STATE)	N / A
N / A M F F BANFLOYERS NAME OR SCHOOL NAME	YESNO	C INSURANCE PLAN NAME OR PROGRAM NAME
N / A	c. OTHER ACCIDENT?	N / A
IN / A INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an I also request payment of government benefits either to myest or to the party who: 	y medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.
Laso request payment of government benefits either to revenie to the party with	accepto acceptions a colon	
SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
	. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM : DD : YY INJURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY 05 22 2008	FROM N A A TO N A
	78.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
[7	7b NP1	FROM N / A TO N / A
RESERVED FOR LOCAL USE		20, OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE OFIGINAL REF. NO.
. 847.2	3.	N/A
1.		23. PRIOR AUTHORIZATION NUMBER
2 724.4	4.	N/A
4. A DATE(S) OF SERVICE B C	D E	F G H I J
FROM TO of FROM	EDURES, SERVICES OR SUPPLIES Explain Unusual Circumstances) DIAGNOSIS	DAYS EPSDT ID. RENDERING S CHARGES OR Family QUAL PROVIDER ID. #
MAN DO YYYY MAN DO YYYY Service I EMIS I CPT/HCP	214. MODIFIER POINTER 1.2	146.90 1 0B MDG1558T3
Level 4 Return Complex Visi		1548389489
09 05 08 Carrier/Insurance	- Payment	-124.76
		I I NPI
		NPI
		1
		I I NPI
		l NPI
		1 NH
		NPI NPI
5 FEDERAL TAX LD. NUMBER	COLINT NO. 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
SSN EIN	23460941 (For govt, claims, see back)	146.90 - 124.76 22.1
1. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND A	ODRESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS, ZIP CODE
INCLUDING DEGREES OR CREDRINTALS RENDERED (If	other than home or office)	Occupational Health Centers
bill and are made a part thereof.) Concer.	DFW Redbird tra Medical Centers	of the Southwest, P.A.
5520 W	estmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
Robert J Stuart, MD Dallas	тх 75237	AUGISON, IA 13001-3003
02/24/2010 DATE 158869		*1003955220 MDG1558TX
UCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS-1500 (08/

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HEALTH INSURANCE CLAIM FORM

PICA		PICA [-
MEDICARE MEDICAID TRICARE CHAMP	VA GRIOUP FECA OTHER	1A. INSURED S 1.D. NUMBER (FOR PROGRAM IN ITEM 1)	
(Medicare II) (Medicaid II) (Sponsor's SSN) (Membe	(100k) 10k (100k) mm 110k	464-88-5121	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	\neg
Evans, Melvin	05 17 1950 M X F	Home Depot #8976	- 1
PATIENT'S ADDRESS (No Street)	5. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	_
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E	- 1
	381 141111		\dashv
YTK	8. PATIENT STATUS		-
DESOTO TX	Single Married Other	Lancaster TX	
ZP CODE TELEPHONE (Include Area Code)	1	ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
75115 972 230-4230	Employed Full-Time Part-Time Student	751461874 912 223-4929	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	\neg
N / A		200805265690001NE	İ
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH	\neg
		MM; DD; YY	
N / A	X YES NO	N A M	
D. OTHER INSURED'S DATE OF BIRTH SEX	b. ALITO ACCIDENT? PLACE (State)	;	
N/A M F	YES NO	N / A	
EMPLOYERS NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
N / A	YES NO	N / A	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGN	NG THIS FORM	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize payment of medical	\neg
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an	y medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.	
I also request payment of government benefits either to myself or to the party who	accepts assignment below		
# T # 11 1 1 1 1 1 1 1 1		SIGNATURE ON FILE	
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNATURE ON FILE	
	. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM DD YY 05 22 2008 INJURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY 05 22 2008	FROM N / A TO N / A	
	7a. 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
i e	75 NPI	FROM N / A TO N / A	
9. RESERVED FOR LOCAL USE	1	20. OUTSIDE LAB? \$ CHARGES	_
Janet DuPertuis		YES NO	
21, DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE N / A ORIGINAL REF. NO. N / A	
, 847.2	3 922.2		
	4	23. PRIOR AUTHORIZATION NUMBER	
21 724.4	4.	N / A	
	D E	F G H I J	
Place PROC	EDURES, SERMICES OR SUPPLIES	I DAYS I EPSUT ID. RENDERING	
FROM TO DI (E MG CPT/HCE	cylain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	\$ CHARGES OR Family QUAL PROVIDER ID. #	
06, 11, 08, 06, 11, 08, 11, 199	214	3 146.90 1 OB MDG1558	
Level 4 Return Complex Visi	t	15483894	89
09 05 08 Carrier/Insurance	- Payment	-124.76	
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	棒刀		
		NPI NPI	
		NP1	
		, , , , , , , , , , , , , , , , , , , ,	
		NPI	
		1 1	
		NPI NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	COUNT NO. 27 ACCEPT ASSIGNMENT? (For govt. daims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE	
	23460941 YES NO	s 146.90 s -124.76 s 22	14
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32, NAME AND A	DORESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE 8 PHONE #. (800) 733-7098	2
(i certify that the statements on the reverse apply to this	other than home or office)	Occupational Health Centers	,
bill and are made a part thereof.)	DFW Redbird tra Medical Centers	of the Southwest, P.A.	
	estmoreland Ste 200	PO Box 9005	
Behant T Street MD		Addison, TX 75001-9005	
02/24/2010 Dallas	77X 75237	*1003955220 *MDG1558TX	
SIGNED DATE 158869	P6033 * · · · · · · · · · · · · · · · · · ·	1003955220 MDG1558TX	-

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HEALTH INSURANCE CLAIM FORM

PICA		PICA 1 1 1
. MEDICARE MEDICAID TRICARE CHAMPUS	HEALTH PLAN BLK LUNG	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	<u>, ', l , l, , , , , , , , , , , , , , , </u>	464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	9. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	0.5 17 1950 M X F 6. PATIENT'S RELATIONSHIP TO INSURED	Home Depot #8976 7. INSURED'S ADDRESS (No Street)
; patient's adoress (No Sweet) 408 Lakewood Dr	Self Spouse Child Other	500 W Interstate 35 F
	8. PATIENT STATUS	CITY STATE
DESOTO TX	Single Married Other	Lancaster TX
ZP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student	751461874 912 223-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N / A		200805265690001NE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
n / A	X YES NO	N/A
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYERS NAME OR SCHOOL NAME
N/A M F	YES NO	N / A
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	CITY Lancaster TX ZP CODE 751461874 912 223-4929 11. INSURED'S POLICY GROUP OR FECA NUMBER 200805265690001NE a. INSURED'S DATE OF BIRTH MM ; DD ; YY N / A ; M F b. EMPLOYER'S NAME OR SCHOOL NAME N / A c. INSURANCE PLAN NAME OR PROGRAM NAME N / A
N / A	YES NO	d. IS THERE ANOTHER HEALTH BENEAT PLAN?
1. INSURANCE PLAN NAME OR PROGRAM NAME NT / 26	10d, RESERVED FOR LOCAL USE 200805265690001NE	
N / A READ BACK OF FORM BEFORE COMPLETING & SIGN		YES NO If YES, return to and complete items 9a-d. 13. INSURED'S OR AUTHORIZED PERSONS SIGNATURE I authorize payment of medical
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of ar I also request payment of government benefits either to myself or to the party who	v medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.
। asso request payment or government centents either to myself or to the party who	worther seefficient recipies.	
SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY 05 22 2008 INJURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD TYY 05 22 2008	FROM N A TO N A
	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DO YY MM DO YY
	7b NPI	FROM N / A TO N / A
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE N / A ORIGINAL REF. NO. N / A
1. 724.4	3 922.2	23. PRIOR AUTHORIZATION NUMBER
0.47 2	•	1
2 847.2	4.	N / A F G H I J S CHARGES OA Family OUAL PROVIDER ID. 96: 34 2 OB PT1148030TX
	D E EDURES, SERVICES OR SUPPLIES	F G H I J
FROM TO of (E	oplain Unusual Circumstances) DIAGNOSIS CS MODIFIER POINTER	S CHARGES OR Femily QUAL PROVIDER ID. #
	530 2,3	
Therapeutic Activities-15m 09 05 08 Carrier/Insurance	- Parmont	
op op carrier/insurance	- rayment	1 1 NPI
06 23 08 06 23 08 11 97	110 1	1 138.63 3 0B PT1148030TX
Therapeutic Exercises-15m		1293923322
09 05 08 Carrier/Insurance	- Payment	-112.53
		I I NPI
		NPI
		NP3
25. FEDERAL TAX LD. NUMBER 26. PATIENT'S AC	COUNT NO 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGES 29. AMOUNT PAID. 30. BALANCE DUE
SSN	23460941 For govt. claims, see back)	; 234,97 ; -191,83 ; 43,14
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32 NAME AND A	DORESS OF FACILITY WHERE SERVICES WERE	33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS, ZIP CODE
INCLUDING DEGREES OR CREDRNTALS RENDERED (If	other than home or office) DFW Redbird	Occupational Health Centers
Concer	tra Medical Centers	of the Southwest, P.A.
1	estmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
	, TX 75237	
SIGNED 02/24/2010 a.158869	6033	*1003955220 *PT1148030TX

HEALTH INSURANCE CLAIM FORM

Sedgwick PO Box 14497	1500		
Lexington, KY 40512-4497	HEALTH INSU	RANCE CLAIM FO	RM
	APPROVED BY NATIONAL UNIFOR	RM CLAIM COMMITTEE 08/05	
PICA MEDICARE MEDICARD TRICARE CH	MAMPVA GROUP FECA OTHE	R 1A INSURED S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
CHAMPUS	PRIDER IDW) ((SSN or ID) BLK LUNG X (ID)	464-88-5121	(a.,
TENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Nam	•
vans, Melvin TENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	Home Depot #897 7. INSURED'S ADDRESS (No Street)	6
08 Lakewood Dr	Self Spouse Child Other	500 N Interstat	e 35 E
DESOTO T	ATE 8. PATIENT STATUS K Single Married Other	Lancaster	STATE TX
DDE TELEPHONE (Include Area Code) 5115 972 230-4230	Employed Suitent Student	751461874	TELEPHONE (INCLUDE AREA CODE) 912 223-4929
#ER INSUREDS NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA N	
/ A		20080526569000	1NE
IER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) X YES NO	a. INSURED'S DATE OF BIRTH	SEX F
IER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	N / A : b. EMPLOYER'S NAME OR SCHOOL NAME	M
/ A M F	YES NO	N / A	
LOYERS NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM N / A	NAME
RANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT I	PLAN?
/ A	200805265690001NE	YES NO	If YES, return to and complete items 9a-d.
READ BACK OF POPM BEFORE COMPLETING & S ATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of also request payment of government benefits either to myself or to the party of	of any medical or other information necessary to process this claim.	13. INSURED'S OR AUTHORIZED PERSON: benefits to the undersigned physician	S SIGNATURE 1 authorize payment of medical or supplier for services described below.
	лю ассерья явзядиняли овом		
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNATU	TRE ON FILE
TE OF CURRENT ; 00 ; YY 5, 22 ; 2008 ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, , GIVE FIRST DATE MM; DD; YY 05: 22: 2008	16. DATES PATIENT UNABLE TO WORK IN	TO MM DD YY
ME OF REPERFING PHYSICIAN OR OTHER SOURCE	05 22 2008	19. HOSPITALIZATION DATES RELATED TO	CURRENT SERVICES MM DD YY
	17b NPI	FROM N / A	TO N / A
served for Local use anet DuPertuis		20. OUTSIDE LAB?	\$ CHARGES
GNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TI	O ITEM 24E BY LINE)	22 MEDICAID RESUBMISSION	OFIGINAL REF. NO /
724.4	31 922.2	N / A 23. PRIOR AUTHORIZATION NUMBER	N / A
847.2	41	N / A	
A DATE(S) OF SERVICE B C	D E	F G ,	1 J
FROM TO O' EMG EMG CPT/	ROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) DIAGNOSIS HCPCS MODIFIER POINTER	DAYS EPS \$ CHARGES OR Far UNITS PI	DT ID. RENDERING rily QUAL PROVIDER ID. #
24 08 06 24 08 11 1 1 9	97530 2,3	96.34 2	OB PT1148030T
erapeutic Activities-15m 05 08 Carrier/Insurance		-79.30	129592352
	97110, 1	138.63 3	OB PT1148030T
erapeutic Exercises 15m	Dormont -	_110! 50	NP 129592352
05 08 Carrier/Insurance	: - rayment	-112.53	NPI
			NPI
			NPI
SSN EIN	ACCOUNT NO. 27 ACCEPT ASSIGNMENT? (For govt claims, see back)	o bana de frances de la companya de	MOUNT PAID . 30. BALANCE DUE
	0023460941 YES NO DIADDRESS OF FACILITY WHERE SERVICES WERE	\$ 234.97 \$	-191 83 , 43/1
LUDING DEGREES OR GREDPATIALS withy that the statements on the reverse apply to this and are made a part thereof.) CMC CONC	o (f other than home or office) - DFW Redbird entra Medical Centers	Occupational He of the Southwes	(800)733-7098 alth Centers
ent M Davis. PT	Westmoreland Ste 200	PO Box 9005 Addison, TX 750	01-9005
02/24/2010 Dall	as, TX 75237 696033	1003955220	PT1148030TX
CC Instruction Manual available at: www.nucc.org			039 0000 FORM CMS 1500 (08/

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HEALTH INSURANCE CLAIM FORM

-CARRIER

PICA									PICA	Щ
MEDICARE MEDICAID TRICARE	CHAMPVA	GROUP	DI ANI	FECA OTHER	1A. INSURED'S I.D. N	UMBER		(FOR PRO	OGRAM IN ITEM 1)	
(Medicare #) (Medicaid #) (Sponsor's SSN)	(Member II	D#) HEALTH ((SSN or	io	(SSN) X (ID)	464-88-	5121				
PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRT	H DATE	SEX	4. INSURED'S NAME (I	ast Name, Fire	t Name, Middle	Initial)		
Evans, Melvin		MM DD	.YY 1950 M	X F	Home De	#0	076			
		05 17 3		<u> </u>	7, INSURED'S ADDRES		3/6		· · · · · · · · · · · · · · · · · · ·	\dashv
PATIENT'S ADDRESS (No Street)		B. PALIENI S ACLA								
408 Lakewood Dr		Self Spo	use Child	Other	500 N I	nterst	ate 3	<u> </u>		
пү	STATE	8. PATIENT STATU	s		CITY				STATE	
DESOTO	TX	Single	Married	Other	Lan	caste	5		TX	
P CODE TELEPHONE (Include Area Code)		'	J <u>-</u>		ZIP CODE		TELEPH	ONE (INCLUDE AF	REA CODE)	
Pres P		Employed	Full-Time	Part-Time	7514618	74	وا	12 223-	4929	
3/2 230 4230			Student	Student	11. INSURED'S POLIC					\dashv
OTHER INSURED'S NAME (Last Name, First Namw, Middle Initial)		10. PATIENT'S CO	NOITION RELAT	ED TO:						
N / A					200805	200091	DOOTHE			
OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT?	(CURRENT OR	PREVIOUS)	a. INSURED'S DATE O	DD YY		Si	ex	
N / A		X	YES	NO 04	N /	A		м	F	
OTHER INSURED'S DATE OF BIRTH SEX		b. AUTO ACCIDEN	T?	PLACE (State)	b. EMPLOYERS NAME	OR SCHOOL	NAME			
MM ; DD ; YY			ו ר	NO PLACE (State)	1	1 / A				1
N / N		┥ 느	YES		c. INSURANCE PLAN I		GRAM NAME	··········		\dashv
EMPLOYERS NAME OR SCHOOL NAME		c. OTHER ACCIDE	√1? 1 ⊏	-		I / A				
N / A			YES	NO	l					
INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED P			d. IS THERE ANOTHE	R HEALTH BE!	NEFIT PLAN?			
N / A		2008	052656	90001NE	YES	NO	If YES,	return to and com	plete Items 9a-d.	
READ BACK OF FORM BEFORE COMPLETIN	G & SIGNIN	G THIS FORM			13. INSURED'S OR AL	THORIZED PE	RSON'S SIGNA	TURE I authorize	payment of medical	
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the refe	sase of any	medical or other infor	mation necessa	ry to process this claim.	benefits to the un	dereigned phy	arcian or supplie	er for services des	CRIDEG DEIOW.	
I also request payment of government benefits either to myself or to the p	esty who ac	лоћия сизадинами <u>по</u> м	·							
GTOND MIDE ON EILE		•	3T / 3		•	STGN	ATURE	ON FILE	2	- 1
SIGNATURE ON FILE		DATE	N / A		SIGNED					
DATE OF CUPRENT ILLNESS (FIRST SYMPTOM) OR		F PATIENT HAS HAD			16. DATES PATIENT L			T OCCUPATION	xo ; vy	
MM DD YY INJURY (ACCIDENT) OR PREGNANCY (LMP)		BIVE FIRST DATE	05 22	2008	FROM N	A ^{DD} Y	το	N / I		
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	. 17a	1 1		i dit	18. HOSPITALIZATION				. YY	
	178	NPI			FROM N	A Y	r . To		i	I
9. RESERVED FOR LOCAL USE		<u> </u>			20. OUTSIDE LAB?		\$ CI	ARGES		\neg
							1	1		- 1
Janet DuPertuis					YES	NO				
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 O	R 4 TO ITEM	124E BY LINE)			22. MEDICAID RESUB		ORIGINAL	L REF. NO.	/ 3	ļ
, 1 724.4		922.2			м/	A	<u> </u>	N	/ A	
1		·		4	23. PRIOR AUTHORIZ	TATION NUMBE	R			
21 847.2		a 1			N /	A				
2. 027.2		<u></u>								
24. A DATE(S) OF SERVICE B C Place	ppoor	D JURIES, SERVICES OF	O CONTROL IEC	E	F	'G	H S EPSDT	<u>.</u>	J RENDERING	
FROM TO of	(Exn	lain Unusual Circums	tances)	DIAGNOSIS POINTER	\$ CHARGES	. OF	Family	ID. XUAL	PROMIDER ID. #	ı
06, 26, 08, 06, 26, 08, 11, I	CPT/HCPC	30.	MODIFIER	2 3	96			B PTI	148030	TX
			ii	2,3	!	1			959235	
Therapeutic Activities-1		. Da	n+	. A.	-79	3U	1			
09 05 08 Carrier/Insuran	ice -	- rayme	11 L		- / 9	. JU		NPI		7
		110	- ; - ;		1 100	حط			11/0020	mv
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Therapeutic Exercises - 15		1 1						12	<u> 2959235</u>	22
09 05 08 Carrier/Insuran	ice -	- Payme	nt ,		-112	.53	் <u> </u> _			
	l				<u>. </u>			NPI		
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	I	1 :		1	, ;	1	1 [-	NPI		
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	l	1 i		14		1	`1 }-	NPI		
	<u> </u>		1	CETT ACCIONS SENTE	1			L	BALANCE	
SSN EIN	TENT'S ACC	.,		CEPT ASSIGNMENT? ovt. daims, see back)	28. TOTAL CHARGE		29. AMOUNT		30. BALANCE DUE	والمراجعة
752014828 X IO	1-002	3460941	YE	es NO		4:97		91,83		114
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAI INCLUDING DEGREES OR CREDRITALS REN	ME AND ADD	RESS OF FACILITY V	VHERE SERVIC	ES WERE	33. PHYSICIAN'S, SI & PHONE #.	JPPLIERS BIL	LING NAME, AD	DRESS, ZIP CODE	733-709	8
(I certify that the statements on the reverse apply to this	•	FW Redb:			Occupat	ional	Healt	h Cente	rs	_
		ra Medic		nters	of the	South	west,	P.A.		
		stmorel			PO Box	9005		0005		
Brent M Davis, PT					Addison	, TX	/5001-	9005		
02/24/2010 Da		TX 752	3.7		\$10030EE	220	li li	PT1148	በ30ሞሃ	
	8869	o∪33 °	31 17 =	· · · · · · · · · · · · · · · · · · ·						ne ins
NUCC Instruction Manual available at: www.nucc.o	org				APPR	OVED O	MB-0938-I	0999 FORM	CMS-1500 (UO/U

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HEALTH INSURANCE CLAIM FORM

PICA MEDICARE MEDICALD TRICARE CHAMP	A GROUP FECA OTHER	1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
MEDICARE MEDICAID TRICARE CHAMPIS (Medicare #) (Medicaid #) (Sponsor's SSN) (Member	HEALTH PLAN BLKLUNG	464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 MX F	Home Depot #8976
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
TY STATE	8. PATIENT STATUS	CITY
DESOTO TX	Single Married Other	Lancaster TX ZP CODE TELEPHONE (INCLUDE AREA CODE)
P CODE TELEPHONE (Indude Area Code)	Full-Time Part-Time	751461874 912 223-4929
75115 972 230-4230	Employed Student Student	11. INSURED'S POLICY GROUP OR FECA NUMBER
OTHER INSURED'S NAME (Last Name, First Namw, Middle Initial) N / A	10, PATIENT'S CONDITION RELATED TO:	200805265690001NE
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N / A	X ves No	N/A
OTHER INSURED'S DATE OF BIRTH SEY	b. AUTO ACCIDENT? PLACE (State)	TX ZP CODE Lancaster ZP CODE 751461874 912 223-4929 11. INSUREDS POLICY GROUP OR FECA NUMBER 200805265690001NE a. INSUREDS DATE OF BIRTH MM
MM DD YY N A M F	YES NO	N / A
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	YES NO	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEAT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d. 13. INSURED S OR AUTHORIZED PERSONS SIGNATURE authorize payment of medical
READ BACK OF FORM BEFORE COMPLETING & SIGN 12. PATIENTS OR AUTHORIZED PERSONS SIGNATURE. I authorize the release of an	y medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.
I also request payment of government benefits either to myself or to the party who	accepts assignment below	
SIGNED SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
DATE OF CURRENT III NESS (BRST SYMPTOM OR 15	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DO YY 05 22 2008 INJURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM 05 20 2008	FROM N A YY TO N A A
	7a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
	7b NPI	FROM N / A TO N / A
9. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO 22. MEDICAID RESUBMISSION
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO IT	022 2	CODE N / A ORIGINAL REF. NO. N / A
1. 724.4	3. 922.2	23. PRIOR AUTHORIZATION NUMBER
21 847.2	4.1	N/A
	D E	F G H I J
FROM TO PROCE	EDURES, SERVICES OR SUPPLIES Polain I bussuel Circumstancest DIAGNOSIS	DAYS EPSDT ID. RENDERING CHARGES DAYS EPSDT ID. PROVIDER ID.
MAN DID YYYY MAN DID YYYY Service EMICS CPT/HCF	530 MODIFIER POINTER 2,3	96.34 2 0B PT1148030TX
Therapeutic Activities-15m	2/3	I I № 1295923522
09.05.08 Carrier/Insurance	- Payment	-79.30
		1 100 cd d 00 00114000000
••••	110 1	138.63 3 0B PT1148030TX 1295923522
Therapeutic Exercises-15m	- Payment	-112.53
09 05 08 Carrier/Insurance	- rayment	-112.33
		1 1
		I I NPI
		1 0
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	(For govt, claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE 23.4.97 \$ -1.91 83 . 43.14
	23460941 YES NO DDRESS OF FACILITY WHERE SERVICES WERE	29 DUMSICIAN'S SUPPLIERS BILLING NAME ADDRESS ZIP CODE
INCLUDING DEGREES OR CREDRITALS RENDERED (II	other than home or office)	Occupational Health Centers
bill and are made a part thereof)	DFW Redbird ntra Medical Centers	of the Southwest, P.A.
	Westmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
Brent M Davis, PT Dalla:	s, TX 75237	
02/24/2010 DATE 15886		*1003955220 PT1148030TX
NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS-1500 (08/05

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HEALTH INSURANCE CLAIM FORM

PICA		PICA TT
1. MEDICARE MEDICAID TRICARE CHAMPY	GROUP FECA OTHER	1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member	DIF) HEALTH PLAN BLK LUNG X (ID)	464-88-5121
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 MX F	Home Depot #8976
5. PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr		500 N Interstate 35 E
	3611 37 3	CITY STATE
CITY	8. PATIENT'STATUS	
DESOTO TX	Single Merried Other	Lancaster TX
ZIP CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student	751461874 912 223-4929
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N / A		200805265690001NE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N / A	X YES NO	N A M
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD YY M F	YES NO NO	N/A
c. EMPLOYERS NAME OR SCHOOL NAME	c OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	YES NO	N / A
d INSUPANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d, IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	l m., m.,
READ BACK OF FORM BEFORE COMPLETING & SIGNIN	L	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any	medical or other information necessary to process this daim.	INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
I also request payment of government benefits either to myself or to the party who ac	cepts assignment below.,	
_{signed} signature on file	DATE N / A	SIGNATURE ON FILE
		SIGNED_STORATORS ON ETHE
14 DATE OF CUPRENT ILLNESS (FIRST SYMPTOM) OR 15. MM ; DD ; YY INJURY (ACCIDENT) OR	F PATIENT HAS HAD SAME OR SIMILAR ILLNESS, BIVE FIRST DATE MM ; DD ; YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM ; DD ; YY TO MM ; DD ; YY
05 22 2008 PREGNANCY (LMP)	05 22 2008	PROM N / A ! N / A !
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 178		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
<u> </u>	NPI	FFOM N / A TO N / A
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? S CHARGES
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITE)	24E BY LINE)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
, 724.4	922.2	N/A
		23. PRIOR AUTHORIZATION NUMBER
2 847.2	.	N/A
24. A DATES OF SERVICE B C	D E	F G H i J
FROM TO PROCEE	UPES, SERVICES OR SUPPLIES	DAYS LEPSOT ID. RENDERING
MM DD YYYY MM DD YYYY Service EMG CPT/HCPC	MODIFIER POINTER	UNITS Plan QUAL PROVIDER ID.
07-01-08-07-01-08-11	.10	138.63 3 OB PT1148030TX
Therapeutic Exercises-15m		112053
09 05 08 Carrier/Insurance -	Payment	112.53
07 01 00 07 01 00 11 1 07	20	
07.01.08 07.01.08 11 975	330, 2,3	90.54 Z [0D] E111400001M
Therapeutic Activities-15m		1293923322
09 05 08 Carrier/Insurance	Payment	-79.30
		1 NPI
		NPI NPI
	1 <u>0</u> 3	3
		NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACC	[For govt. claims, see back)	28, TOTAL CHARGES 29, AMOUNT PAID 30, BALANCE DUE
	3460941 YES NO	s 234.97 s -191.83 s 43.14
INCLUDING DEGREES OR CREDRITALS RENDERED (If of	RESS OF FACILITY WHERE SERVICES WERE ler than home or office)	39. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #. (800) 733-7098
(i certify that the elatements on the reverse apply to this	FW Redbird	Occupational Health Centers
Concent	ra Medical Centers	of the Southwest, P.A.
	stmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
Brent M Davis, PT	TX 75237	
02/24/2010 Dallas, *1588698	033	*1003955220 PT1148030TX

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HEALTH INSURANCE CLAIM FORM

PICA		PICA [] []
MEDICARE MEDICAID TRICARE CHAMP	HEALTH PLAN BLK LUNG	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	LOCAL TO LOCAL SEE UP	464-88-5121
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #8976
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
STATE STATE	8. PATIENT'STATUS	CITY STATE
DESOTO	Single Married Other	Lancaster TX
TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115	Full-Time Part-Time	751461874 912 223-4929
312 230 4230	Employed Student Student	11. INSURED S POLICY GROUP OR FECA NUMBER
D. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10, PATIENT'S CONDITION RELATED TO:	
N / A		200805265690001NE
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY
N/A	X YES NO	N/A M F
B. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYERS NAME OR SCHOOL NAME
N / A W F	YES NO	N / A
E. EMPLOYERS NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	YES NO	N / A
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF PORM BEFORE COMPLETING & SIGN	NG THIS FORM	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE 1 authorize payment of medical
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an I aim request payment of government benefits either to myself or to the party who	y medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.
Laiso request payment or government benefits asset to myosil or to bury who		
SIGNED SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
MM ; DO ; YY INJURY (ACCIDENT) OR	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DO YY	16. DATES PATIENT LIMBLE TO WORK IN CURRENT COCUPATION FROM N / A TO N / A
05: 22:2008 PREGNANCY (LMP)	05 22 2008	18. HOSPITALIZATION DATES RELATED TO CURPENT SERVICES
	7a. NPI	FROM MM DD YY TO MM DD YY
	<u> </u>	N / A N / A :
19. RESERVED FOR LOCAL USE		
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION ORIGINAL REF. NO. N / A
, 724.4	a _. 922.2	
	₩.	23. PRIOR AUTHORIZATION NUMBER
2 847.2	4.	N/A
24. A DATE(S) OF SERVICE B C	D E	F G H I J
FROM TO PROCE	EDURES, SERVICES OR SUPPLIES Volain I busual Circumstancest DIAGNOSIS	DAYS EPSOT ID. RENOGRING S CHARGES OR Family CHAI PROVIDER ID. #
MM DD YYYY MM DD YYYY Service EMG CPT/HCF	CS MODIFIER POINTER	UNITS Plan GOL
	530 2,3	96:34 2 OB PT1148030TX
Therapeutic Activities-15m	- Paymont	79.30
09 05 08 Carrier/Insurance	- rayment	-/9:30
	110	138.63 3 OB PT1148030TX
Therapeutic Exercises-15m	Paranet	110 50
09 05 08 Carrier/Insurance	- Payment	~112.53
1		
		1 NPI
		NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	COUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. daims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
752014828 X 101-00	23460941 YES NO	s 234.97 s -191.83 s 43.14
24 CICAMATI IDE DE DIAVSICIANI DO SI IDDI IED 32 NAME AND A	DORESS OF FACILITY WHERE SERVICES WERE other than home or office)	33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #. (800) 733-7098
at the same of the same of the same	DFW Redbird	Occupational Health Centers
Concer	tra Medical Centers	of the Southwest, P.A.
	estmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
Brent M Davis, PT	TX 75237	· ·
02/24/2010 DATE 158869		*1003955220 PT1148030TX
101001 1 0 11 11 11 11 11		ADDROVED OMR 0038 0000 EORM CMS-1500 (08/05

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HEALTH INSURANCE CLAIM FORM

PICA			PICA !	┷┵:
. MEDICARE MEDICAID TRICARÉ CHAM	PVA GROUP FECA HEALTH PLAN BLK LUNG	OTHER	ER 1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Memb	Licett Im Licett	(ID)	464-88-5121	İ
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	1	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Evans, Melvin	05 17 1950 MX	F	Home Depot #8976	- 1
, PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED		7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child Othe		500 N Interstate 35 E	
			1	
STATI	8. PATIENT STATUS		_	
DESOTO TX	Single Married Other		Lancaster TX	
TP CODE TELEPHONE (Include Area Code)			ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
75115 972 230-4230	Employed Full-Time Part-Time Student Student		751461874 912 223-4929	
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	<u></u>	11. INSURED'S POLICY GROUP OR FECA NUMBER	\neg
N / A			200805265690001NE	
				\dashv
I. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)		a. INSURED'S DATE OF BIRTH SEX	- 1
N/A	X YES NO		N/A M F	_
OCTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLAC	E (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	ŀ
N / A	YES NO		N/A	
EMPLOYER'S NAME OR SCHOOL NAME	6. OTHER ACCIDENT?		C. INSURANCE PLAN NAME OR PROGRAM NAME	
N / A	YES NO		N / A	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE		4. IS THERE ANOTHER HEALTH BENEFIT PLAN?	-
	200805265690001N	ne.		
N / A			YES NO If YES, return to and complete items 9a-d.	\dashv
READ BACK OF FORM BEFORE COMPLETING & SIGN		io drim	 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: authorize payment of medical benefits to the undersigned physician or supplier for services described below. 	
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of a liaiso request payment of government benefits either to myself or to the party who 	ny mesical or osier information necessary to process in accepts assignment below	uam		
	•			
SIGNED SIGNATURE ON FILE	DATE N / A		SIGNATURE ON FILE	
	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,		AS DATED DATED IN THE ETO MODELLO DOCUMENTO COCHEATION	-
MM DD VY INLEY (ACCIDENT) OR	. GIVE FIRST DATE MM ; DO ; YY		16. DATES PATIENT UNABLE TO WORK IN CUPRENT OCCUPATION DO YY TO MM DD YY TO TO THE DESTRUCTION OF THE DES	1
05 22 2008 PREGNANCY (LMP)		2.44	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
•	178.		MM DD YY MM DD YY	
	17b NPI		N/A TO N/A	_
9. RESERVED FOR LOCAL USE			20. OUTSIDE LAB? \$ CHARGES	
Janet DuPertuis			YES NO	
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO F	EM 24E BY LINE)		22. MEDICALD RESUBMISSION	\neg
704 4	s.i 847.2		COOE N / A ORIGINAL REF. NO. N / A	
1. 724.4	3. 047.2	7	23. PRIOR AUTHORIZATION NUMBER	\neg
			_	
2 922.2	4		N / A	
24. A DATE(S) OF SERVICE B C		E	F G H I J	
FROM TO PROC	CEDURES, SERVICES OR SUPPLIES Explain Unusual Circumstances) DIA	GNOSIS	DAYS EPSOT ID. RENDERING S \$ CHARGES OR Family CHAIL PROVIDER ID. #	- 1
MM DD YYYY MM DD YYYY Service EMG CPT/HC	PCS MODIFIER PC	DINTER	UNITS Plan COAL	┈
	⁷ 530 2	. 2.	96.34 2 OB PT1148030	섨
Therapeutic Activities-15m	!		12959235	44
09 05 08 Carrier/Insurance	- Payment		79.30	
<u> </u>			NPI NPI	
08 04 08 08 04 08 11 9	7110 3	19	92:42 2 OB PT1148030	
Therapeutic Exercises-15m			NP 12959235	22
09 05 08 Carrier/Insurance	- Payment	81	75,02	
			NPI NPI	
08 04 08 08 04 08 11 1 9	7001 59 1		124:.93 1 OB PT1148030	TX
PT Eval		• •	12959235	
	- Parmont		1 -95: 60	
09 05 08 Carrier/Insurance	- rayment			
			NP1	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S A	CCOUNT NO. 27.ACCEPT ASSIGNM (For govt. daims, see	ENT? back)	28, TOTAL CHARGES 29, AMOUNT PAID 30, BALANCE DUE	
A CONTRACT OF THE PROPERTY OF	23460941 YES N	*	s 313 69 s -249 92 s 63	77
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND A	DDRESS OF FACILITY WHERE SERVICES WERE		33 PHYSICIAN'S SUPPLIERS BILLING NAME ADDRESS ZIP CODE	
INCLUDING DEGREES OR CREDRNTALS (I certify that the statements on the reverse apply to this	other than home or office)		Occupational Health Centers	5
bill and are made a part thereof.)	DFW Redbird ntra Medical Centers		of the Southwest, P.A.	
	Vestmoreland Ste 200		PO Box 9005	
Brent M Davis, PT			Addison, TX 75001-9005	
02/24/2010 Dalla	s, TX 75237	257		
	6033	na i	*1003955220 PT1148030TX	
NUCC Instruction Manual available at: www.nucc.org			APPROVED OMB-0938-0999 FORM CMS-1500 (0)8/05

-CARRIER

Sedgwick PO Box 14497 Lexington, KY 40512-4497

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HEALTH INSURANCE CLAIM FORM

PICA		•	PICA
MEDICARE MEDICAID TRICARE CHAMPI	/A GROUP FECA OTHER	1A. INSURED'S I.D. NUMBER	(FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Member	IDIF) HEALTH PLAN BLK LUNG X (ID)	464-88-5121	
PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Midd	ile Initial)
Evans, Melvin	05 17 1950 MX F	Home Depot #8976	
, PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 3	35 E
CITY	8. PATIENT STATUS	CITY	STATE
DESOTO TX	Single Married Other	Lancaster	TX
ZP CODE TELEPHONE (Include Area Code)			PHONE (INCLUDE APIEA CODE)
75145	Full-Time Part-Time		912 223-4929
912 230-4230	Employed Student Student	11. INSURED'S POLICY GROUP OR FECA NUMBER	312 223-4323
D. OTHER INSURED'S NAME (Lest Name, First Name, Middle Initial) N / A	10. PATIENT'S CONDITION RELATED TO:	200805265690001NI	
	4		3
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY	SEX C
N/A	X YES NO	N/A	M F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b, EMPLOYER'S NAME OR SCHOOL NAME	
N / A M F	YES NO	N / A	
c. EMPLOYER'S NAME OR SCHOOL NAME	e. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	STATE TX PHONE (INCLUDE AREA CODE) 912 223-4929 R SEX M F
N/A	YES NO	N / A	
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
N / A	200805265690001NE	YES NO HYE	S, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN!		13. INSURED'S OR AUTHORIZED PERSON'S SIGN	
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any I also request payment of government benefits either to myself or to the party who a 	medical or other information necessary to process this claim.	benefits to the undersigned physician or supp	Men let aprilion udalilies beich.
		•	
SIGNATURE ON FILE	DATE N / A	SIGNATURE SIGNATURE	ON FILE
	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURR	ENT OCCUPATION
MM ; DD ; YY 05 22 2008 HUURY (ACCIDENT) OR PREGNANCY (LMP)	GIVE FIRST DATE MM DD YY 05 22 2008	MM: DD : YV	O N / A
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17		18. HOSPITALIZATION DATES RELATED TO CURP	ENT SERVICES
	7b NPI	FROM N / A	TO N / A
19. RESERVED FOR LOCAL USE	1 1		CHARGES
Janet DuPertuis		YES NO	1
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITE	M 24E BY LINE	22. MEDICAID RESUBMISSION	
		CODE N / A ORIGIN	IAL REF. NO. N / A
1. 724.4	3. 922.2	23. PRIOR AUTHORIZATION NUMBER	-
047 0	.1		
2 847.2	4.	N / A	
24. A DATE(S) OF SERVICE B C PROCE	D E DURES, SERVICES OR SUPPLIES	F G H DAYS EPSDT	I J
FROM TO of FMC! (5)	Triangle Comments of the Chicago	S CHARGES OR Family UNITS Plan	ID. RENDERING QUAL PROVIDER ID. #
08 06 08 08 06 06 08 11 1 97	530 1		OB PT1148030TX
Therapeutic Activities-15m			1295923522
09 05 08 Carrier/Instrance	- Payment	-79.30	<u></u>
			NPI
08 06 08 08 06 08 11 97	110, 1,2,	B 92.42 2	OB PT1148030TX
Therapeutic Exercises - 15m			NA 1295923522
09 05 08 Carrier/Insurance	- Payment	-75.02	
			NPI
		第二十二屆 1	
			NPI
	, ,	\$45 T.A	
			NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACC	COUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. daime, see back)	28. TOTAL CHARGES 29. AMOUN	IT PAID 30. BALANCE DUE
and the control of th	23460941 YES NO		154 32 , 34 44
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND AD	DRESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, A	DDRESS, ZIP CODE
(I certify that the statements on the reverse apply to this	other than home or office) DFW Redbird	Occupational Healt	(800) 733-7098
Concen	tra Medical Centers	of the Southwest,	
5520 W	estmoreland Ste 200	PO Box 9005	-9005
Brent M Davis, PT	. TX 75237	Addison, TX 75001-	-9005
02/24/2010 Dallas SIGNED 02/24/2010 *158869		*1003955220	PT1148030TX
1 20000	I Section 1999		

Case 3:10-cv-02059-BD Document 1-1 Filed 10/13/10 Page 20 of 81 PageID 100

CARRIER

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HEALTH INSURANCE CLAIM FORM

		PICA TT
1 PICA 1. MEDICARE MEDICAID TRICARE CHAM	VA GROUP FECA OTHER	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Memb	HEALTH PLAN BLKLUNG	464-88-5121
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	MM DD YY	
	05 17 1950 M X F	Home Depot #8976 7. INSURED'S ADDRESS (No Street)
5. PATIENT'S ADDRESS (No Steet)		
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E
CITY STATI	8. PATIENT STATUS	
DESOTO TX	Single Married Other	Lancaster TX
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student Student	Lancaster
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N/A		200805265690001NE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N/A	X YES NO	N/A: MI
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
MM DD W	YES NO	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	N / A c. INSURANCE PLAN NAME OR PROGRAM NAME
N/A	YES NO	N/A
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N/A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN	ING THIS FORM	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of a late request payment of government benefits either to myself or to the party who	ny medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.
(state tedness bayment or descriptions desired in this series of many with	accepts accept main 2001.	
SKENED SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
		15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY INJURY (ACCIDENT) OR	5. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY 05: 22: 2008	MM,;_DD;YY TO MM;DD;YY
05 22 2008 PREGNANCY (LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	05 22 2008	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
1	17b NPI	FROM MM DD YY MM DD YY
	175 147 1	N / A ON / A
19. RESERVED FOR LOCAL USE		
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO I	EM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE N / A ORIGINAL REF. NO. N / A
1 724.4	3 922.2	23. PRIOR AUTHORIZATION NUMBER
2. 847.2	4.	N/A
24. A DATE(S) OF SERVICE B C	D E	F G H I J
	EDURES, SERVICES OR SUPPLIES Splain Unusual Circumstances) DIAGNOSIS ROUNTER	S CHARGES OR Family QUAL PROVIDER ID. #
08: 07:08:08: 07: 08: 11: 1 9:		96.34 2 OB PT1148030TX
Therapeutic Activities-15m		I I № 1295923522
09 05 08 Carrier/Instrance	- Payment	-79:30
		1 NPI
08 07 08 08 07 08 11 9	110 1,2,	B 92.42 2 OB PT1148030TX
Therapeutic Exercises-15m		NFI 1295923522 1
09 05 08 Carrier/Insurance	- Payment	-75 02
1		i I NPI
9 % 1 B 1		N
		I NPI
		NPI
25. FEDERAL TAX.I.D. NUMBER SSN EIN 26. PATIENT'S A	COUNT NO. 27 ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID . 30. BALANCE DUE
SSN EIN)23460941 YES NO	188.76 -154.32 34.44
31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32. NAME AND	DDRESS OF FACILITY WHERE SERVICES WERE	33 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS, ZIP CODE
INCLUDING DEGREES OR CREDRNTALS (I certify that the statements on the reverse apply to this	other than home or office) DFW Redbird	Occupational Health Centers
Conce	tra Medical Centers	of the Southwest, P.A.
	Westmoreland Ste 200	PO Box 9005 Addison, TX 75001-9005
Brent M Davis, PT	s, TX 75237	AULION, IN 15001-5005
02/24/2010 a 15886		-1003955220 PT1148030TX

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HEALTH INSURANCE CLAIM FORM

PICA		PICA 1 []
MEDICARE MEDICAID TRICARE CHAMPA	HEALTH PLAN BLK LUNG	1A INSURED S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponeor's SSN) (Member		464-88-5121
PATIENT'S NAME (Leat Name, First Name, Middle Initial)	S. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Evans, Melvin	05 17 1950 M X F	Home Depot #8976
PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED S ADDRESS (No Street)
408 Lakewood Dr	Sett Spouse Child Other	500 N Interstate 35 E
TTY STATE	8. PATIENT STATUS	CITY STATE
DESOTO TX	Single Married Other	Lancaster TX
SP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Full-Time Part-Time Student	751461874 912 223-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N / A		200805265690001NE
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N / A	X YES NO	N / A Y
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
N / A	YES NO	n / A
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	YES NO	N / A
LINSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN	NG THIS FORM	13. INSURED S OR AUTHORIZED PERSONS SIGNATURE 1 authorize payment of medical
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an I also request payment of government benefits either to reyself or to the party who a	medical or other information necessary to process this claim.	benefits to the undersigned physician or supplier for services described below.
i ann tadaga balumur ar Annattitatit nastaven onng en tilhaut et en ein bestå atter	·	
SIGNATURE ON FILE	DATE N/A	SIGNATURE ON FILE
	IF PATIENT HAS HAD SAME OR SIMILAR ILLINESS,	16 DATES PATIENT LINARI E TO WORK IN CURRENT OCCUPATION
	GIVE FIRST DATE MM DD YY 05 22 2008	FROM N A DD YY TO N A A
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
T. ING. CO. TELL ESTREET	7b NPI	FROM N / A TO N / A
9. RESERVED FOR LOCAL USE	1 1	N / A N / A
Janet DuPertuis		Tyes Tho
	M 24F RY LINE	22. MEDICAID RESUBMISSION
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITE	000 0	CODE N / A ORIGINAL REF. NO. N / A
724.4	3. 922.2	23. PRIOR AUTHORIZATION NUMBER
	•	
2 847.2	4.	N / A
24. A DATE(S) OF SERVICE B C	D E	F G H I J I DAYS EPSDT ID RENDERING
FROM TO of (E	EDURES, SERVICES OR SUPPLIES optain Unique Circumstances) DIAGNOSIS POINTER POINTER	S CHARGES OR Family OUAL PROVIDER ID. RENDERING S CHARGES OR Family OUAL PROVIDER ID.
MIN DO TITT MIN DO TITT	530, : MODIFIER POINTER	96.34 2 OB PT1148030TX
Therapeutic Activities-15m		I I NP 1295923522
09 10 08 Carrier/Insurance	- Payment	ı –79:30 l
		1 I NPI
08 11 08 08 11 08 11 97	110 1,2,	B 92.42 2 OB PT1148030TX
Therapeutic Exercises-15m		1 1295923522 NP 1295923522
09 10 08 Carrier/Insurance	- Payment	-75.02
		NPI NPI
		1 331
		1 I NPI
	*	
		NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	COUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
28N CIA	23460941 YES NO	: 188.76 : -154 32 : 34.44
31, SIGNATURE OF PHYSICIAN OR SUPPLIER 32, NAME AND A	DDRESS OF FACILITY WHERE SERVICES WERE	33 PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE
INCLUDING DEGREES OR CREDRNTALS (I certify that the statements on the reverse apply to this	other than home or office)	Occupational Health Centers (800) 733-7098
hill and are made a part thereof \	DFW Redbird tra Medical Centers	of the Southwest, P.A.
	estmoreland Ste 200	PO Box 9005
Brent M Davis, PT	TX 75237	Addison, TX 75001-9005
02/24/2010 DATE 158869	1 eps-1 3,339 3 3.79 1 3.79 1 3	*1003955220 PT1148030TX
NUCC Instruction Manual available at: www.nucc.org		APPROVED OMB-0938-0999 FORM CMS-1500 (08/0

Document 1-1 Filed 10/13/10 Page 22 of 81 PageID 102

Sedgwick PO Box 14497 Lexington, KY 40512-4497

1500

HEALTH INSURANCE CLAIM FORM

. MEDICARE MEDICAID TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLKL	OTHER	1A. INSURED S I.D. NUMBER		(FOR PROGRAM IN	TITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN)	(Member II	1	(SSN)	X (D)	464-88-5121			
PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DA	,	, SEX	4. INSURED'S NAME (Last Name, Fi	rst Name, Middle Initia	Ŋ	
Evans, Melvin		6 PATIENTS RELATION			7. INSURED'S ADDRESS (No Street)		<u>-</u> -	
, PATIENTS ADDRESS (No Street) 408 Lakewood Dr		Self Spouse	Child	Other	500 N Inters		2	
OITY	STATE	8. PATIENT STATUS	[~		CITY			STATE
DESOTO	TX		Married	Other	Lancaste	r		TX
ZIP CODE TELEPHONE (Include Area		'-			ZIP CODE	TELEPHONE	(INCLUDE AREA CODE	€).
75115 972 230-42	30		ull-Time sudent	Part-Time Student	751461874	912	223-492	9
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. PATIENT'S CONDIT	ION RELATED TO):	11. INSURED'S POLICY GROUP OR			
N / A					20080526569	0001NE		
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CUI	RRENT OR PREV	10US)	a. INSURED'S DATE OF BIRTH MM DD Y	Υ	SEX _	l'
N / A b. OTHER INSURED'S DATE OF BIRTH SEX		X YE	s	io ·	N A :	M NAME	F	<u> </u>
MM ; DD ; YY	_	b. AUTO ACCIDENT?		PLACE (State)	n/A			
N / A M F		a. OTHER ACCIDENT?	'لــا'	~	c. INSURANCE PLAN NAME OR PRO	OGRAM NAME		
N / A		YE	s	NO ON	n/A			TX 9 9
I, INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR L			d. IS THERE ANOTHER HEALTH BE	ENEFIT PLAN?		
n / A		200805	2656900	001NE	YES NO	If YES, return	to and complete item	19 9a-d.
READ BACK OF FORM BEFORE COMP			n naconner te	rocess this claim	13. INSURED'S OR AUTHORIZED P benefits to the undersigned ph			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the later request payment of government benefits either to repetit or to	the party who acc	pepts assignment below	AT HOLOSSERY 10 D	TOO STATE				
CTCMAMIDE ON ETTE		NT.	/ 3		SIGN	NATURE ON	FILE	
SIGNATURE ON FILE			/ A		SIGNED			
DATE OF CURRENT ILLNESS (FIRST SYMPTOM) MM : DD : YY 05; 22; 2008 ILLNESS (FIRST SYMPTOM) PREGNANCY (LMP)	OR 15.11	F PATIENT HAS HAD SAM BIVE FIRST DATE MI C	5 22 2	YY .	FROM N A	Y то	N / A	**
7, NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a.			<u>.</u>	18. HOSPITALIZATION DATES RELA	^	ERVICES MM DD	٧٧
	17b	NPI			N/A	то	N/A	
o reserved for local use Janet DuPertuis					20. OUTSIDE LAB?	\$ CHARG	es 	·
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,	2 3 OR 4 TO ITEM	124F RY LINE)			YES NO 22. MEDICAID RESUBMISSION			
	,2,00.14.70.1.0	1 844 9			CODE N / A	ORIGINAL REF	NO. N / A	
1. 724.4				₩	23. PRIOR AUTHORIZATION NUMB	ER		
2 847.2	4	u]			N/A			
24. A DATE(S) OF SERVICE B C	Τ	D	_	. Е	F G	н	J	RING PRID. #
FROM TO of	/Exn	URES, SERVICES OR SUF lain Unusual Circumstance	98)	DIAGNOSIS	• CHADGES OF	YS EPSDT 1D. R Family ITS Plan QUAL	RENDE PROVIDE	PING PRID.#
08:13:08:08:13; 08: 11:	м ^G I сетинсеся I 975		DIFIER	POINTER 2	144.51	3 0B	PT1148	XT020E
Therapeutic Activities					<u> </u>	NPI NPI	12959	923522
09 26 08 Carrier/Insur	ance -	- Payment	, ji	1.162	-118.95	1		
	1 ==-	10		a - iX:	B 6 92 12	O OD	Dm1 1 44	3030TX 923522
08 13 08 08 13 08 11	971	TTO :	i i	1,2,	B 92.42	2 OB	PT1148	923522
Therapeutic Exercises - 09 19 08 Carrier/Insur		- Payment		· 13e .	-75.02	1 1	1233.	
Coloratelymous	- I		[[NPI		
THE STATE OF THE S	· 1 4			1.%	i i i	7		
	1		<u>: : :</u>		1 1	l NPI		
	*							
	i			LOGIOLE STATE		NPI	1	
SSN EIN	S. PATIENT'S ACCO		(For govt. da	ASSIGNMENT? ims, see back)	28. TOTAL CHARGES	29. AMOUNT PAID	1	42.796
· · · · · · · · · · · · · · · · · · ·		3460941 RESS OF FACILITY WHEF	YES E SERVICES WE	NO RE	\$ 236.93 33. PHYSICIANS, SUPPLIERS BIT		3 97 s	
INCLUDING DEGREES OR CREDRITALS	RENDERED (If ot	her than home or office)	-	al No	occupational		(800) 733	-7098
bill and are made a part thereof.)		FW Redbird ra Medical		ers	of the South			
		stmoreland			PO Box 9005 Addison, TX	75001-90	05	
		TX 75237						
SIGNED 02/24/2010 A	1588696						T1148030	
NUCC Instruction Manual available at: www.nu	cc.org				APPROVED C)MB-0938-099	9 FORM CMS	-1500 (08/05)

--- CARRIER

Sedgwick PO Box 14497 Lexington, KY 40512-4497

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HEALTH INSURANCE CLAIM FORM

PICA		PICA
I. MEDICARE MEDICAID TRICARE CHAMPUS	HEALTH PLAN BLK LUNG	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Membe	((SSN or ID) (SSN) X (ID)	464-88-5121
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Leet Name, First Name, Middle Initial)
Evans, Melvin	6. PATIENT'S RELATIONSHIP TO INSURED	Home Depot #8976 7. INSURED'S ADDRESS (No Street)
5. PATIENT'S ADDRESS (No Steet) 408 Lakewood Dr		' ' '
		500 N Interstate 35 E
CITY STATE	8. PATIENT STATUS Single Married Other	
DESOTO TELEPHONE (include Area Code)	Single Married Other	ZP CODE TELEPHONE (INCLUDE AREA CODE)
75115 972 230-4230	Employed Student Student	751461874 912 223-4929
9/2 23U-423U 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
N / A	1901 / STILLING OF CONTROL FILLING LAW 190.	200805265690001NE
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH SEX
N / A	X YES NO	N / A
b. OTHER INSUREDS DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYERS NAME OR SCHOOL NAME
MM / DD YY	YES NO STATE	N / A
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
N / A	YES NO	N / A
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
N / A	200805265690001NE	YES NO If YES, return to and complete items 9a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGN		13. INSURED S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of an I also request payment of government benefits either to myself or to the party who. 	y medical or other information necessary to process this claim. accepts assignment below	
	<u></u> . <u></u>	CTMINITE ON ETTE
SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE
A DATE OF CURPENT ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DO YY 05 22 2008	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM N / A TO N / A
	a.	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY
	7b NPI	FROM N / A TO N / A
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
Janet DuPertuis		YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO IT	EM 24E BY LINE)	22. MEDICAID RESUBMISSION CODE N / A ORIGINAL REF. NO. N / A
1 724.4	922.2	21 / 22
	V	23. PRIOR AUTHORIZATION NUMBER
2 847.2	4 844.9	N/A
24. A DATE(S) OF SERVICE B C PROC	D E	F G H I J
FROM TO of (E.M. MM DD YYYY MM DD YYYY Service EMG CPT/HCP	miain Unusual Circumstances) DIAGNOSIS	\$ CHARGES OR Family OUAL PROVIDER ID. #
08 15 08 08 15 08 11 1 97	530 2,3	144.51 3 OB PT1148030TX
Therapeutic Activities-15m		1295923522
09 26 08 Carrier/Insurance	- Payment	-118.95
08 15 08 08 15 08 11 97	110 1,4	92.42 2 OB PT1148030TX
Therapeutic Exercises-15m		NP 1295923522
09 26 08 Carrier/Insurance	- Payment	-75.02
		I NPI
		1
		NPI NPI
		\\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\
	27.ACCEPT ASSIGNMENT?	NPI NPI
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S AC	(For govt. claims, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE
	23460941 YES NO	\$ 236.93 \$ -193.97 \$ 42.96
INCLUDING DEGREES OR CREDRITALS RENDERED (If	DRESS OF FACILITY WHERE SERVICES WERE other than home or office)	33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE 2. PHONE #. (800) 733-7098
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)	DFW Redbird	Occupational Health Centers of the Southwest, P.A.
	tra Medical Centers estmoreland Ste 200	PO Box 9005
Brent M Davis, PT		Addison, TX 75001-9005
02/24/2010 Dallas	75237 6033	*1003955220 PT1148030TX
SIGNED DATE 158869	つし33 	1 1003955280 PT1148030TX

Liberty Mutual Home Depot ONLY PO Box 7072 London, KY 40742-7072

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HEALTH INSURANCE CLAIM FORM

PICA		PICA	
I. MEDICARE MEDICAID TRICARE CHAMPV.	HEALTH PLAN BLK LUNG	1A. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member		464-88-5121	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	9. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Evans, Melvin	05 17 1950 M X F	Home Depot #8976	
5. PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	İ
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E	
CITY	8. PATIENT STATUS	CITY	
DESOTO TX	Single Married Other	Lancaster TX	
ZIP CODE TELEPHONE (Include Area Code)	1	ZIP CODE TELEPHONE (INCLUDE AREA CODE)	
75115 972 230-4230	Employed Full-Time Part-Time Student Student	751461874 912 223-4929	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
N / A		WC 14C-007670	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIFTH SEX	
N / A	X YES NO	N A W	
b. CTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
NY A M F	YES NO	N / A	
C. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
N / A	YES NO	N / A	
I. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	$\neg \neg$
N / A	WC 14C-007670	YES NO If YES, return to and complete items 9a-d.	
READ BACK OF FORM BEFORE COMPLETING & SIGNIN	G THIS FORM	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE authorize payment of medical	-
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any I also request payment of government benefits either to myself or to the party who ac		benefits to the undersigned physician or supplier for services described below.	.
•	· -		
SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE	1
	F PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
MM ; DD ; YY INJURY (ACCIDENT) OR ,	GIVE FIRST DATE MM DD YY 04 22 2009	I BOW WHY (DO ; YY TO MM ; DO ; YY	
04 22 2009 PREGNANCY (LMP) 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 178		18: HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
	Nei	FROM DD YY MM DD YY	
19. RESERVED FOR LOCAL USE	1 1	N / A N / A N / A 20. OUTSIDE LAB?	
LAURA MAZIOL		Tyes Tho	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM	424E BY LINE)	22. MEDICAID RESUBMISSION	\dashv
		CODE N / A ORIGINAL REF. NO. N / A	Ì
1 724.4	3	23. PRIOR AUTHORIZATION NUMBER	
947 2	*		
2 847.2	4.	N/A	
24. A DATE(S) OF SERMICE B C PROCEE	D E SUPPLIES	F G H I J DAYS I EPSOT ID RENDERING	
FROM TO of (Exp MM DD YYYY MM DD YYYY Service EMG CPT/HCPCS	Jain I burnist Circumstances DIACNOSIS	\$ CHARGES OR Family QUAL PROVIDER ID. #	
04 23 09 04 23 09 11 1 1 992	214, , , , 1,2	146.90 1 0B MDG1558	
Level 4 Return Complex Visit		15483894	189
05 22 09 Carrier/Insurance -		1 -129.27	
		NP)	
		NPI NPI	
]
		NPI NPI	
] NPI	
		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCO	DUNT NO. 27.ACCEPT ASSIGNMENT? (For govt. dairns, see back)	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE	I
	23696725 YES NO		: 63
INCLUDING DEGREES OR CREDRINTALS RENDERED (If of	RESS OF FACILITY WHERE SERVICES WERE then than home or office)	33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE & PHONE #. (800) 733-709	8
(I certify that the statements on the reverse apply to this bill and are made a part thereof.) CMC — I	FW Redbird	Occupational Health Centers	-
Concent	ra Medical Centers	of the Southwest, P.A. PO Box 9005	
1	estmoreland Ste 200	Addison, TX 75001-9005	
	тх 75237		
SIGNED DATE 1588696	5033 b.	*1003955220 b MDG1558TX	
MICC Instruction Manual available at: www.nucc.org		ADDDOVED OMD 0039 0000 EODM CMS.1500 (100 IDE

Case 3:10-cv-02059-BD Document 1-1 Filed 10/13/10 Page 25 of 81 PageID 105

Liberty Mutual Home Depot ONLY PO Box 7072 London, KY 40742-7072

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HEALTH INSURANCE CLAIM FORM

PICA MEDICAID TRICARE CHAMPY:	GROUP FECA OTHER	1A INSURED S I.D. NUMBER (FOR PROGRAM IN ITEM 1)		
CHAMPUS [HEALTH PLAN BLK LUNG	464-88-5121		
(Medicare #) (Medicaid #) (Sponsor's SSN) (Member I		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
Evans, Melvin	05 17 1950 MX F	Home Depot #8976		
PATIENT'S ADDRESS (No Street)		7. INSURED'S ADDRESS (No Street)		
408 Lakewood Dr	Self Spouse Child Other	CITY Lancaster TX ZP CODE TELEPHONE (INCLUDE AREA CODE) 751461874 912 223-4929 11. INSUREDS POLICY GROUP OR FECA NUMBER WC 14C-007670 a. INSUREDS DATE OF BIRTH MM DD YY N A M F b. EMPLOYERS NAME OR SCHOOL NAME N / A c. INSURANCE PLAN NAME OR PROGRAM NAME N / A		
		CITY STATE		
''		Lancaster TX		
DESOTO TX		ZP CODE TELEPHONE (INCLUDE AREA CODE)		
CODE TELEPHONE (Include Area Code)	Full-Time Part-Time	751461874 912 223-4929		
75115 972 230-4230	Employed Student Student	11. INSURED'S POLICY GROUP OR FECA NUMBER		
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	WC 14C-007670		
N / A		HO 140 007070		
OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY F		
N / A	X YES NO	N A M b. EMPLOYERS NAME OR SCHOOL NAME		
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	0)		
N / A M F	YES MO	N / A c. INSURANCE PLAN NAME OR PROGRAM NAME		
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	N / A		
N / A	YES NO	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?		
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE			
N/A	WC 14C-007670	YES NO If YES, return to and complete items 9a-d.		
READ BACK OF FORM BEFORE COMPLETING & SIGNIF 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE i authorize payment of medical benefits to the undersigned physician or supplier for services described below.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Factorize are released to any Laiso request payment of government benefits either to myself or to the party who as	coepts assignment below			
SIGNATURE ON FILE	DATE N / A	SIGNED SIGNATURE ON TIME		
	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM ; DD ; YY	16. DATES PATIENT UNABLE TO WORK IN CURPENT OCCUPATION MM ; DD ; YY		
04 22 2009 INJURY (ACCIDENT) OR PREGNANCY (LMP)	04 22 2009	FROM N / A TO N / A		
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 17.		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MN DD YY FROM TO TO TO TO TO TO TO TO TO TO TO TO TO		
17	NPI NPI	N/A N/A		
). RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES		
LAURA MAZIOL		YES NO		
21. DIAGNOSIS OR NATURE OF ILLINESS OR INJURY, (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 22. MEDICAID RESUBMISSION CODE CODE CODE CODE CODE CODE CODE CODE		CODE ORIGINAL REF, NO		
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23. PRIOR AUTHORIZATION NUMBER		21. PRIOR AUTHORIZATION NUMBER		
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24. A DATESS OF SERVICE B C	D E	F G H I J		
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		NP 1548389489		
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25, FEDERAL TAX I.D. NUMBER 26. PATIENT'S AC	COUNT NO. 27 ACCEPT ASSIGNMENT?	28. TOTAL CHARGES 29. AMOUNT PAID 30. BALANCE DUE		
SSN EIN	23696725 For govt. claims, see back)	146.90 -129.27 , 17.63		
31 SIGNATURE OF PHYSICIAN OR SUPPLIER 32, NAME AND AL	DORESS OF FACILITY WHERE SERVICES WERE	AND PRACTICALLY SUPPLIEDS BY LING NAME ADDRESS 7/P CODE		
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of the Southwest, P.A.				
FOR THE WAR AND SHOULD BOX 9005				
Robert J Stuart, MD Pallas, TX 75237 Dallas, TX 75237				
02/24/2010 DATT 158869	6033			
NUCC Instruction Manual available at: www.nucc.ord APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)				

Liberty Mutual Home Depot ONLY PO Box 7072 London, KY 40742-7072

1500

HEALTH INSURANCE CLAIM FORM

PICA			PICA
1. MEDICARE MEDICAID TRICARE CHAMPV.	A GROUP FECA OTHER	1A. INSURED S I.D. NUMBER (FOR PF	ROGRAM IN ITEM 1)
(Medicare #) (Medicald #) (Sponsor's SSN) (Member		464-88-5121	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
Evans, Melvin	05 17 1950 MX F	Home Depot #8976	
5. PATIENT'S ADDRESS (No Street)	6. PATIENT'S RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No Street)	
408 Lakewood Dr	Self Spouse Child Other	500 N Interstate 35 E	•
CITY STATE	8. PATIENT STATUS	CITY	STATE
DESOTO TX			TX
ZP CODE TELEPHONE (Include Area Code)	Single Married Other	Iancaster ZP CODE TELEPHONE (INCLUDE A	
75445	Full-Time Part-Time		
912 230-4230	Employed Student Student	751461874 912 223	-4929
OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
N / A		WC 14C-007670	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM : DO : YY	SEX
N / A	X YES NO	N/A	F
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
M DD YY	YES NO	N/A	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	c. INSURANCE PLAN NAME OR PROGRAM NAME	
N / A	YES NO	N / A	
IL INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
N / A	WC 14C-007670		
		YES NO If YES, return to and con	
READ BACK OF FORM BEFORE COMPLETING & SIGNIN 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize benefits to the undersigned physician or supplier for services des	
I also request payment of government benefits either to myself or to the party who ac	cepts assignment below		
·			-
SIGNATURE ON FILE	DATE N / A	SIGNATURE ON FILE	E .
4 DATE OF CURRENT ILLNESS (FIRST SYMPTOM) OR 15.1	F PATIENT HAS HAD SAME OR SIMILAR ILLNESS,	15. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	
04 22 2009 INJURY (ACCIDENT) OR PREGNANCY (LMP)	04 22 2009	EDOM _MM ; DD ; YY TO MM ; I	DD ; YY A. :
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE 178	V 22 2003	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
177	NPI	FROM (i to ti	DD . YY ZA
19. RESERVED FOR LOCAL USE	<u> </u>	N / A N / 1 20. OUTSIDE LAB? \$ CHARGES	A ;
LAURA MAZIOL			
	DOME TO LINES	YES NO	·
21. DIAGNOSIS OR NATURE OF ILLINESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM	·	22. MEDICAID RESUBMISSION CODE N / A ORIGINAL REF. NO.	/ A
724.4	842.02		<i>,</i> .
	₩	23. PRIOR AUTHORIZATION NUMBER	
2 847.2	847.1	n/A	
24. A DATE(S) OF SERVICE B C	D E	F G H I	J
FROM TO PAGE PROCED	URES, SERVICES OR SUPPLIES lain Unupual Circumstances) DIAGNOSIS	I DAVE LEPSOT II	RENDERING
MM DD YYYY MM DD YYYY Service EMG CPT/HCPCS	MODIFIER POINTER	UNITS Plan QUAL	PROVIDER ID.
			MG1558TX
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06 05 09 Carrier/Insurance -	Payment	-135.69	
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		NP:	
25. FEDERAL TAX.I.D. NUMBER 26. PATIENT'S ACCO	OUNT NO. 27.ACCEPT ASSIGNMENT?	<u> </u>	30. BALANCE DUE
SSN EIN	(For govt. claims, see back)	150,000 105,00	02154
		<u> </u>	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDINITALS 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE INCLUDING DEGREES OR CREDINITALS 33. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE 8. PHONE #. (800) 733-7098			733-7098
(i certify that the statements on the reverse apply to this bill and are made a part thereof.) CMC - DFW Redbird Concentra Medical Centers		Occupational Health Cente	rs
	of the Southwest, P.A. PO Box 9005		
Robert J Stuart, MD	stmoreland Ste 200	Addison, TX 75001-9005	
02/24/2010 Dallas.	TX 75237		
SIGNED 02/24/2010 -1588696	033	*1003955220 MDG155	8TX

SOMMERMAN & OCISCE DOCUMENT 1-1

3811 TURTLE CREEK BOULEVARD, SUITE 1400

3811 TURTLE CREEK BOULEVARD, SUITE 1400

BOULEVARD, SUITE 1400

Filed 10/13/10

Page 27 of SIDREWED SOMMERMAN †
GEORGE (1EX) OUESADA ††
HEATHER LONG ††
TELEPHONE 214-720-0720

TOLL FREE 800-900-5373

TELECOPIER 214-720-0184

PRINCE PRIN

March 30, 2010

Board Certified in Personal Printing Trial Law
Beard Certified in Civil Trial Law
Beard Civil Trial Advocate:
National Board of Trial Advocacy
† College of the State Bar of Texas
†† Licensed in Texas and New Mexico
††† Licensed in Texas and District of Columbia

Clerk

County Court at Law No. 1 George L. Allen, Sr. Courts Building 600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of Plaintiff's Notice of Filing Affidavits for Business and/or Medical Records with regard to the referenced lawsuit. Please return a file-marked copy of this pleading to us in the enclosed self-addressed, stamped envelope.

By copy of this letter, all counsel are being served with a copy of this pleading.

Thank you for your usual courtesy and cooperation in these matters.

Sincerely yours,

Norma Pecina,

Legal Assistant to Steven S. Schulte

:np Enclosures

cc w/encl:

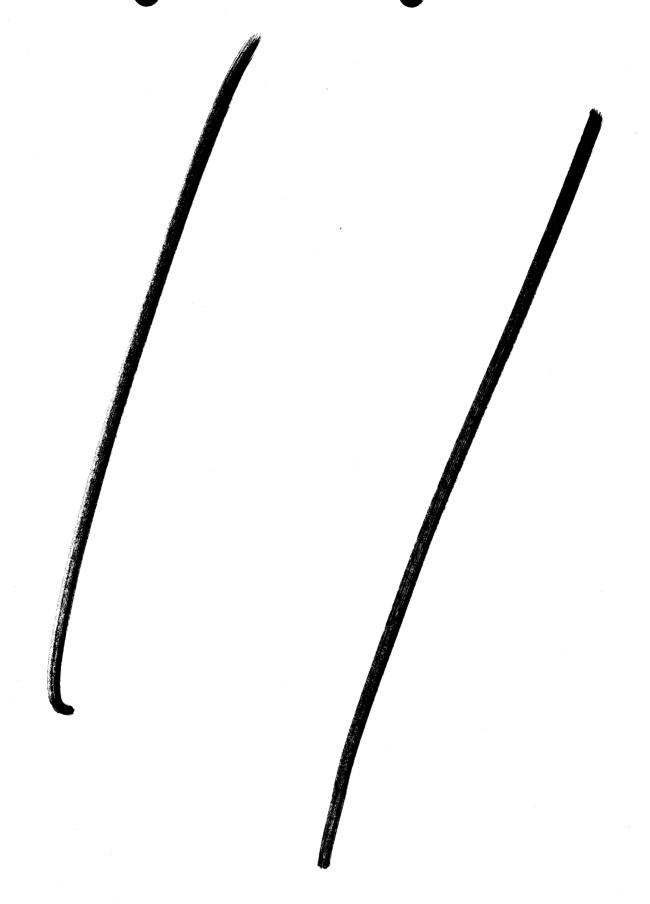
VIA FAX 512/370-2850

Peyton N. Smith

Winstead PC

401 Congress Ave., Suite 2100

Austin, TX 78701



SOMMERNAN & OSS BADA, T. L.P. Filed 10/13/10

3811 TURTLE CREEK BOULEVARD, SUITE 1400 DALLAS, TEXAS 75219
TELEPHONE 214-720-0720
TOLL FREE 800-900-5373
TELECOPIER 214-720-0184
Personalinjury@textrial.com
www.textrial.com

Page 29 of 81 PageID 109
ANDREW B. SOMMERMAN †
GEORGE (FEX) QUESADA ††
HEATHER LONG ††
STEVEN S. SCHULTE

ONIN APR 16 PM SALBBIST

MARY ALICE MCLARTY †††

*Board Certified in Personal Injury/Trial Law
*Board Certified in Ovil Trial Law
Certified Civil Trial Advocate:
National Board of Trial Advocacy
† College of the State Bar of Texas
† Licensed in Texas and New Mexico
††† Licensed in Texas and District of Columbia

April 16, 2010

Clerk County Court at Law No. 1 George L. Allen, Sr. Courts Building 600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

SCANNED

Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of an Agreed Level 3 Scheduling Order. Please present this Order to the Judge for signing, and once signed, please provide our office with a conformed copy to the underlying attorney in the envelope enclosed.

Thank you for your usual courtesy and cooperation in these matters.

Sincerely yours,

Norma Pecina,

Legal Assistant to Steven S. Schulte

:np

Enclosures

cc w/encl:
VIA FAX 512/370-2850
Peyton N. Smith
Winstead PC
401 Congress Ave., Suite 2100
Austin, TX 78701

3811 TURTLE CREEK BOULEVARD, SUITE 1400

BD, Bocument 1P1 Filed 10/13/10 Page 31 of 81 Page

GEORGE (TEX) QUESADA †† HEATHER LONG †† STEVEN S. SCHULTE

> *AL ELLIS†*** Of Counsel

MARY ALICE MCLARTY †††

Of Counsel *Board Certified in Personal Injury Trial Law

**Board Certified in Civil Trial Law ▲ Certified Civil Trial Advocate: National Board of Trial Advocacy † College of the State Bar of Texas †† Licensed in Texas and New Mexico ††† Licensed in Texas and District of Columbia

2010 APR 19 PM 3: 19

COUNTY CLERK April 16, 2010 DALLAS COUNTY

Clerk

DALLAS, TEXAS 75219

TELEPHONE 214-720-0720 TOLL FREE 800-900-5373

TELECOPIER 214-720-0184

personalinjury@textrial.com www.textrial.com

> County Court at Law No. 1 George L. Allen, Sr. Courts Building 600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

> > Re:

Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of a Rule 11 Agreement between counsel regarding discovery in the referenced matter. Please file this document and return a file-marked copy to us via our runner.

By copy of this letter, all counsel are being served with a copy of this pleading.

Thank you for your usual courtesy and cooperation in these matters.

Sincerely yours,

Norma Pecina,

Legal Assistant to Steven S. Schulte

:np **Enclosures**

cc w/encl:

VIA FAX 512/370-2850

Peyton N. Smith

Winstead PC

401 Congress Ave., Suite 2100

Austin, TX 78701

Sommers Andrews Sommers 171 Filed 10/13/10 Page 33 of 81 Page!

3811 TURTLE CREEK BOULEVARD, SUITE 1400 DALLAS, TEXAS 75219
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TOLL FREE 800-900-5373
TELECOPIER 214-720-0184

personaliniury@textrial.com
www.textrial.com

2010 HAY -3 PM 3:01

ANDREW B. SOMMERMAN † GEORGE (TEX) QUESADA †† HEATHER LONG †† STEVEN S. SCHULTE

*AL ELLIS†***
Of Counsel

MARY ALICE McLARTY †††
Of Counsel

*Board Certified in Personal Injury Trial Law
**Board Certified in Civil Trial Law
* Certified Civil Trial Advocate:
National Board of Trial Advocacy
† College of the State Bar of Texas
†† Licensed in Texas and New Mexico

April 30, 2010

VIA CM/RRR XO. 7008 1140 0002 8349 6830

Peyton N. Smith Winstead PC 401 Congress Ave., Suite 2100 Austin, TX 78701

Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, U.S.A., Inc.

Dear Mr. Smith:

Enclosed you will find the following:

SCANNEL

- 1. Plaintiff's Responses to Defendant's Request for Disclosure;
- 2. Plaintiff's Objections and Answers to Defendant's Interrogatories; and
- 3. Plaintiff's Objections and Responses to Defendant's Request for Production.

In accordance with the Texas Rules of Civil Procedure, the original documents will be kept in our possession. By copy of this letter, the court clerk is being notified of service of these documents.

If you should have any questions, please do not hesitate to contact our office.

Sincerely

Steven S. Schulte

SSS:nlp

cc w/o encl:

Çlerk

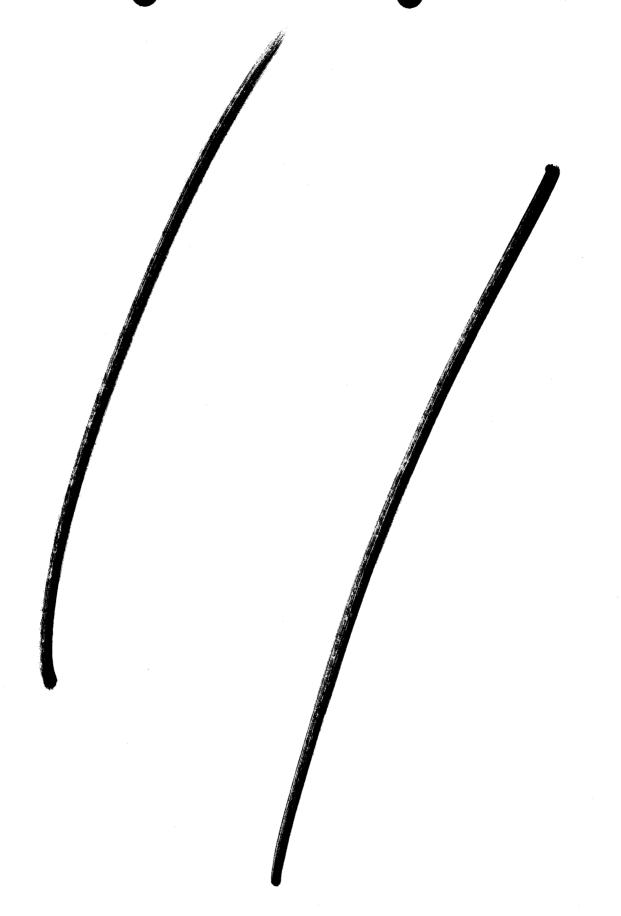
County Court at Law No. 1

George L. Allen, Sr. Courts Building

600 Commerce Street, 5th Floor

Dallas, Texas 75202-4606





3811 TURTLE CREEK BOULEVARD, SUITE 1400

DALLAS, TEXAS 75219

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personalinjury@textrial.com www.textrial.com

Clerk

TOLL FREE 800-900-5373

Document 172 Filed 10/13/10

Page 35 of 81 Pagell

GEORGE (TEX) QUESADA †† HEATHER LONG ## STEVEN S. SCHULTE

> *AL ELLIS†*** Of Counsel

Of Counsel Board Certified in Personal Injury Trial Law **Board Certified in Civil Trial Law

▲ Certified Civil Trial Advocate: National Board of Trial Advocacy † College of the State Bar of Texas †† Licensed in Texas and New Mexico ††† Licensed in Texas and District of Columbia

2010 MAY -6 PM 2: 33

May 4, 2010

County Court at Law No. 1 George L. Allen, Sr. Courts Building

600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

Re:

Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.



Dear Clerk:

This letter is to notify you that I will be on vacation from Monday, June 14 through Wednesday, June 30, 2010.

I respectfully request that the Court set no hearings or trials for these dates. By copy of this letter, I have further requested that no depositions or other matters be scheduled by counsel in the above referenced matter during this period.

Thank you for your assistance and cooperation in this regard.

With kind regards,

/s/ Andrew B. Sommerman

Andrew B. Sommerman

ABS:dr

N:\Active\4500\4597\Correspondence\vacation ltr 050410.wpd

cc:

VIA FAX 512/370-2850 Peyton N. Smith Winstead PC 401 Congress Ave., Suite 2100 Austin, TX 78701



May 07, 2010

KEN RUBENSTEIN 4514 COLE AVE STE 1450 DALLAS TX 75205

Cause No.CC-10-01305-A MELVIN EVANS vs. HOME DEPOT, U.S.A, INC In the County Court at Law No. 1 of Dallas County, Texas

All Counsel of Record:

TREK DOYLE
WINSTEAD SECHREST & MINICK P C
401 CONGRES AVE, STE 2100
AUSTIN TX 78701

STEVEN S SCHULTE 3811 TURTLE CREEK BLVD SUITE 1400 DALLAS TX 75219-4461 SCANNED

The parties are instructed to cross-serve this notice on all adverse parties in compliance with Texas Rule of Civil Procedure 21a.

(1) JURY TRIAL: February 08, 2011 @ 9:00 AM

Sincerely,

County Court at Law No. I
Policies and Procedures
Can be reviewed at
www.judgedmetriabenson.com

Judge D'Metria Benson County Court at Law No. 1 Dallas County, Texas



(214) 653-6581

May 07, 2010

TREK DOYLE WINSTEAD SECHREST & MINICK P C 401 CONGRES AVE, STE 2100 AUSTIN TX 78701

Cause No.CC-10-01305-A MELVIN EVANS vs. HOME DEPOT, U.S.A, INC In the County Court at Law No. 1 of Dallas County, Texas

All Counsel of Record:

The parties are instructed to cross-serve this notice on all adverse parties in compliance with Texas Rule of Civil Procedure 21a.

(1) JURY TRIAL: February 08, 2011 @ 9:00 AM

Trial announcements in ALL cases must be made in accordance with Local Rule 3.02(a). When no announcement is made for Plaintiff, the case may be dismissed for want of prosecution. When no announcement is made for Defendant, Defendant will be presumed ready.

An agreed or unopposed motion for continuance, even for a first trial setting, will NOT automatically be granted. Counsel (or pro se parties) are responsible for contacting court personnel to determine if a continuance has been granted or denied. FAILURE TO APPEAR FOR TRIAL MAY RESULT IN CASE DISMISSAL OR DEFAULT JUDGMENT, AND EVEN AN AGREED OR UNOPPESED MOTION TO REINSTATE WILL NOT AUTOMATICALLY BE GRANTED.

Completion of discovery, presentation of pretrial motions and other matters relating to preparation for trial are governed by the Local Rules of Civil Courts of Dallas County available from the County Clerks office and at www.dallascourts.com/resources.htm.

Sincerely,

County Court at Law No.1 Policies and Procedures Can be reviewed at www.judgedmetriabenson.com

Judge D'Metria Benson County Court at Law No. 1 Dallas County, Texas

County Court at Law No. 1 George Allen Courts Bldg 600 Commerce St. 5th Floor Dallas, TX 75202 (214) 653-6581

SCANNED

May 07, 2010

STEVEN S SCHULTE 3811 TURTLE CREEK BLVD SUITE 1400 DALLAS TX 75219-4461

Cause No.CC-10-01305-A MELVIN EVANS vs. HOME DEPOT, U.S.A, INC In the County Court at Law No. 1 of Dallas County, Texas

All Counsel of Record:

The parties are instructed to cross-serve this notice on all adverse parties in compliance with Texas Rule of Civil Procedure 21a.

(1) JURY TRIAL: February 08, 2011 @ 9:00 AM

Trial announcements in ALL cases must be made in accordance with Local Rule 3.02(a). When no announcement is made for Plaintiff, the case may be dismissed for want of prosecution. When no announcement is made for Defendant, Defendant will be presumed ready.

An agreed or unopposed motion for continuance, even for a first trial setting, will NOT automatically be granted. Counsel (or pro se parties) are responsible for contacting court personnel to determine if a continuance has been granted or denied. FAILURE TO APPEAR FOR TRIAL MAY RESULT IN CASE DISMISSAL OR DEFAULT JUDGMENT, AND EVEN AN AGREED OR UNOPPESED MOTION TO REINSTATE WILL NOT AUTOMATICALLY BE GRANTED.

Completion of discovery, presentation of pretrial motions and other matters relating to preparation for trial are governed by the Local Rules of Civil Courts of Dallas County available from the County Clerks office and at www.dallascourts.com/resources.htm.

Sincerely,

County Court at Law No.1
Policies and Procedures
Can be reviewed at
www.judgedmetriabenson.com

Judge D'Metria Benson County Court at Law No. 1 Dallas County, Texas Case 3:10-cv-02059-BD Document 1-1 SOMMERMAN & QUESADA, L.L.P.

3811 TURTLE CREEK BOULEVARD, SUITE 1400 DALLAS, TEXAS 75219
TELEPHONE 214-720-0720
TOLL FREE 800-900-5373
TELECOPIER 214-720-0184
personalinjury@textrial.com
www.textrial.com

*ANDREW B. SOMMERMAN †
GEORGE (TEX) QUESADA ††
HEATHER LONG ††
STEVEN S. SCHULTE

*AL ELLIS†*** Of Counsel

MARY ALICE McLARTY †††

*Board Certified in Personal Injury Trial Law
*Board Certified in Civil Trial Law
Certified Civil Trial Advocate:
National Board of Trial Advocacy
† College of the State Bar of Texas
†† Licensed in Texas and New Mexico

May 14, 2010

Filed 10/13/10

VIA FAX: 512/370-2850
Peyton N. Smith

Winstead PC 401 Congress Ave., Suite 2100

Austin, TX 78701

Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, U.S.A., Inc.

Dear Mr. Smith:

Attached you will find the following:

SCANNED

- 1. Jury Trial Notice reflecting jury trial on February 8, 2011;
- 2. Mediation Order appointing Ken Rubenstein as mediator; and
- 3. Conformed Agreed Level 3 Scheduling Order.

If you should have any questions, please do not hesitate to contact our office.

Sincerely,

Andrew B. Sommerman

ABS:nlp Attachments

cc w/o encl:

Clerk
County Court at Law No. 1
George L. Allen, Sr. Courts Building
600 Commerce Street, 5th Floor
Dallas, Texas 75202-4606



JOHN F. WARREN **Dallas County Clerk** George Allen Sr. Court Bldg. 600 Commerce St, Ste 101 Dallas, Texas 75202-3551

STATE OF TEXAS

§

COUNTY OF DALLAS

I, John F. Warren, Clerk of the County Court of Dallas County Court at Law No. 1, Dallas County, Texas do hereby certify that the foregoing is a true and correct copy of document in Cause No. CC-10-01305-A.

MELVIN EVANS, PLAINTIFF (S)

VS

HOME DEPOT, U.S.A, INC, DEFENDANT (S)

PLAINTIFF'S DESIGNATION OF LEAD COUNSEL, FILED: MAAY 21, 2010 Minutes of County Court at Law No. 1, Dallas County, Texas.

WITNESS MY HAND AND SEAL of said Court this 5th day of October, 2010.

John F. Warren, County Clerk

ALVIN BECK, Deputy

CAUSE NO. CC-10-01305-A

FILED

MELVIN EVANS,	§	IN THE COUNTY	
21.1.100	§		2010 MAY 21 PM 3: 35
Plaintiff,	§		
	§		INHIN E WARREN
VS.	8	AT LAW NO.1	COUNTY CLERK
	8		JOHN F. WARREN COUNTY CLERK DALLAS COUNTY
HOME DEDOT HIGH INC	8		
HOME DEPOT, U.S.A., INC.	8		
	§ .		
Defendant.	§	DALLAS COUNTY, TEXAS	

PLAINTIFF'S DESIGNATION OF LEAD COUNSEL

TO THE HONORABLE JUDGE OF SAID COURT:

COMES NOW, Melvin Evans, Plaintiff in this action, and hereby designates Andrew B. Sommerman as lead counsel on his behalf to have full control and management of this cause and to receive all communications from the Court or other counsel relating to the case at the following address and telephone number:

> Andrew B. Sommerman Sommerman & Quesada, L.L.P. 3811 Turtle Creek Boulevard, Suite 1400 Dallas, Texas 75219-4461 Telephone (214) 720-0720 Fax (214) 720-0184

> > E-mail: andrew@textrial.com

Respectfully submitted,

SOMMERMAN & QUESADA, L.L.P.

Andrew B. Sommerman State Bar No. 18842150

3811 Turtle Creek Boulevard, Suite 1400

Dallas, Texas 75219-4461

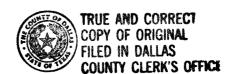
Telephone: Facsimile:

(214) 720-0720 (214) 720-0184

E-mail:

andrew@textrial.com

ATTORNEYS FOR PLAINTIFF



CERTIFICATE OF SERVICE

I hereby certify by my signature above that a true and correct copy of the foregoing instrument has this date been sent to all attorneys of record in the above-styled and numbered cause, said service being effected in the following manner on the day of May, 2010.

Certified Mail/Return Receipt Requested	
Hand Delivery	
Telecopy	<u> </u>
Regular Mail	

Case 3:10-cv-02059-BD Document 1-1. Filed 10/13/10 DOMMER MAN & QUESADA, L.L.P.

0 **Page** 46 of

Page 46 of 81 PageID 126

*ANDREW B. SOMMERMAN † GEORGE (TEX) QUESADA †† HEATHER LONG †† STEVEN S. SCHULTE

STEVEN S. SCHULT

2010 MAY 21 PM 3: 35

*AL ELLIS†***
Of Counsel

MARY ALICE McLARTY †††
Of Counsel

JOHN F. WARREN

Of Counsel

COUNTY CLER Roard Certified in Personal Injury Trial Law

††† Licensed in Texas and District of Columbia

DALLAS COUNTY

*Board Certified in Civil Trial Advocate:

*National Board of Trial Advocacy
† College of the State Bar of Texas
†† Licensed in Texas and New Mexico

May 18, 2010

Via Hand Delivery

3811 TURTLE CREEK BOULEVARD, SUITE 1400

DALLAS, TEXAS 75219

TELEPHONE 214-720-0720 TOLL FREE 800-900-5373

TELECOPIER 214-720-0184

personalinjury@textrial.com www.textrial.com

Clerk
County Court at Law No. 1
George L. Allen, Sr. Courts Building
600 Commerce Street, 5th Floor
Dallas, Texas 75202-4606

Re:

Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of Plaintiff's Designation of Lead Counsel. Please file this document and return a file-marked copy of same to us via the awaiting courier.

By copy of this letter, all counsel are being served with a copy of this pleading.

Thank you for your assistance in this matter.

Sincerely,

Debbie Rima, Legal Assistant to

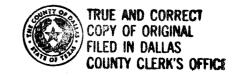
Andrew B. Sommerman

DR/nlp

N:\Active\4500\4597\Correspondence\Clerk 051810 filing Plf's Design Lead Counsel.wpd

cc:

VIA FAX 512/370-2850
Peyton N. Smith
Winstead PC
401 Congress Ave., Suite 2100
Austin, TX 78701







CAUSE NO. CC-10-01305-A

MELVIN EVANS.

IN THE COUNTY

Plaintiff.

AT LAW NO.1

VS.

HOME DEPOT, U.S.A., INC.

Defendant.

DALLAS COUNTY, TEXAS

PLAINTIFF'S MOTION TO QUASH, FOR PROTECTION FROM DISCOVERY, AND OBJECTIONS TO DEPOSITIONS BY WRITTEN QUESTIONS

TO THE HONORABLE JUDGE OF SAID COURT:

NOW COMES Plaintiff Melvin Evans, Movant herein, and bring this Motion to Quash, for Protection from Discovery, and Objections against Defendant. Plaintiff asks the Court to quash the deposition on written questions notice of Solace Counseling Associates and/or Dr. Dhiren Paten, DO, and to issue a protective order.

A. Introduction

- 1. Plaintiff is Melvin Evans. Defendant is Home Depot, U.S.A., Inc.
- 2. Plaintiff brought suit against Defendant for personal injury based upon his claim of negligence.
 - Discovery in this suit is governed by a Level III discovery control plan. 3.

B. Facts

- 4. Plaintiff was served on July 28, 2010 with Defendant's Notice of Deposition by Written Questions and Subpoena Duces Tecum directed to Solace Counseling Associates and/or Dr. Dhiren Paten, DO. See Exhibit A, attached hereto.
- 5. Plaintiff asks the Court to sign a protective order restricting access to and dissemination of the medical and billing records of Solace Counseling Associates and/or Dr. Dhiren Paten, DO as they pertain to the irrelevant medical history of Plaintiff.

C. Argument & Authorities

- 6. This deposition by written questions is not reasonably limited in time or scope to the events or issues related to this litigation.
- 7. This deposition by written questions seeks information that violates the physician-patient privilege (Tex. R. Evid. 509; Tex. R. Civ. P. 193.3). Only medical conditions and/or medical records that relate "in a significant way to a party's claim or defense" are discoverable. *R.K. v. Ramirez*, 887 S.W.2d 836 (Tex. 1994); *Groves v. Gabriel*, 874 S.W.2d 660 (Tex. 1994); *Mutter v. Wood*, 744 S.W.2d 600 (Tex. 1988).
- 8. Defendant is not entitled to forage through Plaintiff Melvin Evans' medical records simply because he has made a claim for physical injury. Litigants do not have a license to engage in "fishing expeditions" into privileged matters. *In Re Jane Doe*, 22 S.W.3d 601 (Tex. App. Austin 2000) (*relying on Coates v. Whittington*, 758 S.W.2d 749 (Tex. 1988) and *Ginsberg v. Fifth Court of Appeals*, 686 S.W.2d 105 (Tex. 1985)).
- 9. The only medical condition of Plaintiff Melvin Evans that has any legal significance to either party's claim(s) or defense(s), are the injuries described in *Plaintiff's Original Petition*. Any other medical conditions, if any, contained in his medical records are privileged under Texas Rules of Evidence 509. Under *R.K.* and *In Re Doe* and in accordance with the live pleadings in this case, neither tangential, irrelevant nor unrelated medical conditions would be properly submitted to a jury to determine Defendant's negligence, negligence per se, or the conclusory allegation of contributory negligence asserted by Defendant's attorneys (although not directly asserted by Defendant itself).
- 10. A trial court has discretion to protect a party with a protective order. Tex. R. Civ. P. 192.6; *Axelson, Inc. v. McIlhany*, 798 S.W.2d 550, 553 (Tex. 1990). The court has the authority to limit the scope of discovery based on the needs and circumstances of the case. Tex. R. Civ. P. 192, cmt. 7.

- Plaintiff asks the Court for a protective order because Defendant's discovery 11. request is over broad. Tex. R. Civ. P. 192, cmt. 1. A discovery request must be reasonably tailored to include only relevant matters. In re American Optical Corp., 988 S.W.2d 711, 713 (Tex. 1998). The Supreme Court has identified as overbroad requests encompassing time periods, products, or activities. See In Regarding: CSX Corp., 124 S.W.3d 149, 153 (Tex. 2003) (request to identify all safety employees of defendant over 30-year period was over broad); American Optical, 988 S.W.2d at 713 (request for production of almost every document relating to asbestos that defendant had ever produced for 50 years was over broad); K-Mart Corp. v. Sanderson, 937 S.W.2d 429, 431 (Tex. 1996) (request for information about criminal conduct at location for seven years was over broad); Dillard Dep't Stores, Inc. v. Hall, 909 S.W.2d 491, 492 (Tex. 1995) (request for every similar claim from every store was over broad). The requests in this case are over broad as to the time period and relevancy to the matter at hand. Plaintiff objects to the depositions by written questions because all depositions call for the healthcare providers to produce for inspection and photocopying "Any and all medical records....".
- 12. Plaintiff Melvin Evans has **not** waived his federally protected privacy rights under HIPPA relating to his medical records. Plaintiff has **not** provided Defendant with a general medical release to permit Defendant to forage through Plaintiff's medical records.

D. Prayer

14. For these reasons, Plaintiff asks the Court to quash Defendant's deposition notice and issue an order protecting Plaintiff from Defendant's improper 'deposition upon written questions' seeking "Any and all" of Plaintiff's medical and billing records from Solace Counseling Associates and/or Dr. Dhiren Patel, DO.

Respectfully submitted,

SOMMERMAN & QUESADA, L.L.P.

Andrew B. Sommerman State Bar No. 18842150

3811 Turtle Creek Boulevard, Suite 1400 Dallas, Texas 75219 214/720-0720 (Telephone)

214/720-0184 (Facsimile)

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF CONFERENCE

	A conference has been held on the merits of this Motion.
X	I have been unsuccessful in my attempts to contact the attorney for the Defendant.
<u> </u>	I have been unsuccessful in my attempts to discuss this matter with the Defendant's attorney as said attorney has not returned my telephone calls or responded to my letter.
	This matter has been discussed with opposing counsel and no agreement on the Motion could be reached.
	Defendant's attorney has agreed or is unopposed to Movant's request under this Motion.

CERTIFICATE OF SERVICE

I hereby certify by my signature above that a true and correct copy of the foregoing instrument has this date been sent to all attorneys of record in the above-styled and numbered matter, said service being effected in the following manner:

Certified Mail/Return Receipt Requested	
Hand Delivery	
Telecopy	
Regular Mail	
DATED: $8/4/0$	

BDAPOKunTent 172 Filed 10/13/10°

3811 TURTLE CREEK BOULEVARD, SUITE 1400 DALLAS, TEXAS 75219 TELEPHONE 214-720-0720 TOLL FREE 800-900-5373 TELECOPIER 214-720-0184 personalinjury@textrial.com www.textrial.com

MARY ALICE MCLARTY ††† COUNTY Board Petitlied in Personal Injury Trial Law

erlified Civil Trial Advocate: National Board of Trial Advocacy t College of the State Bar of Texas tt Licensed in Texas and New Mexico ††† Licensed in Texas and District of Columbia

Board Certified in Civil Trial Law

August 3, 2010

Via Hand Delivery

Clerk County Court at Law No. 1 George L. Allen, Sr. Courts Building 600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

> Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of Plaintiff's Motion to Quash, for Protection from Discovery, and Objections to Depositions by Written Questions and proposed Order. Please file this document and return a file-marked copy of the Motion to us via the awaiting courier.

By copy of this letter, all counsel are being served with a copy of this pleading.

Thank you for your assistance in this matter.

Sincerely.

ndrew B. Sommerman

ABS:dr

Encl

N:\Active\4500\4597\Correspondence\Clerk 080310 filing M-Quash.wpd

cc:

VIA FAX 512/370-2850 Peyton N. Smith Winstead PC 401 Congress Ave., Suite 2100 Austin, TX 78701

VIA FAX 512/476-7202 Waterloo Litigation Support, Inc. 1505 W. 44th Street Austin, TX 78756

vs.

HOME DEPOT, U.S.A., INC.

Defendant.

AT LAW NO.1

DALLAS COUNTY, TEXAS

PLAINTIFF'S NOTICE OF FILING RULE 11 AGREEMENT

COMES NOW Plaintiff and files with the Court this his NOTICE OF FILING RULE 11
AGREEMENT (Exhibit A) attached hereto.

Respectfully submitted,

SOMMERMAN & QUESADA, L.L.P.

Andrew B. Sommerman

State Bar No. 18842150

3811 Turtle Creek Boulevard, Suite 1400

Dallas, Texas 75219-4461

Telephone:

(214) 720-0720

Facsimile:

(214) 720-0184

E-mail:

andrew@textrial.com

ATTORNEYS FOR PLAINTIFF

CERTIFICATE OF SERVICE

I hereby certify by my signature above that a true and correct copy of the foregoing instrument has this date been sent to all attorneys of record in the above-styled and numbered cause, said service being effected in the following manner on the 8th day of September, 2010.

Certified Mail/Return Receipt Requested	
Hand Delivery	
Telecopy	
Regular Mail	·

Filed 10/13/10

3811 TURTLE CREEK BOULEVARD, SUITE 1400 DALLAS, TEXAS 75219 TELEPHONE 214-720-0720 TOLL FREE 800-900-5373 TELECOPIER 214-720-0184 personalinjury@textrial.com

2010 SEP-9 PM 2:39

JOHN F WADDEN. B GEORGE (TEX) QUESADA †† HEATHER LONG 11N

*AL ELLIS†*** Of Counsel

www.textrial.com MARY ALICE MCLARTY ††† Of Counsel

September 8, 20

*Board Certified in Personal Injury Trial Law **Board Certified in Civil Trial Law ▲ Certified Civil Trial Advocate: National Board of Trial Advocacy † College of the State Bar of Texas †† Licensed in Texas and New Mexico ††† Licensed in Texas and District of Columbia

Clerk County Court at Law No. 1 George L. Allen, Sr. Courts Building

600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

Re:

Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of Plaintiff's Notice of Filing Rule 11 Agreement. Please file this document and return a file-marked copy of the Motion to us in the enclosed self addressed envelope.

By copy of this letter, all counsel are being served with a copy of this pleading.

Thank you for your assistance in this matter.

Sincerely,

Legal Assistant

cc:

VIA FAX 512/370-2850 Trek C. Dovle Winstead PC 401 Congress Ave., Suite 2100 Austin, TX 78701

SOMMERMAN & QUESADA, L.L.P.

3817 TURTLE CREEK BOLLEVARD, SUITE 1400 DALLAS, TEXAS 75218 TELEPHONE 214-720-0720 TOLL FREE 800-900-5973 TELECOPIER 214-720-0184 personalitivo Pleatrill com

ANDREW B SOMMERMAN T GEORGE (TEX) QUESADATT

"AL ELLIST" Of Counsel

moo.tsmag www MARY ALICE MCLARTY TTT OI COURSE!

-Board Centified in Persural Injury That Law -Board Centified in Crut That Law ~ Corafied CMI That Advocate. National Board of That Advocacy 7 Counge of the State Bar of Texas AL Problem to James and Mark Welco TTY Liberisto in Texas and District of Columba

September 8, 2010

VIA FAX: 512/370-2850 Trek C. Dayle Winstead HC 401 Congress Ave., Suite 2100 Austin, TX 78701

Rei Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, U.S.A., Inc.

Dear Mr. Doyle:

Please allow this letter to serve as our Rule 11 Agreement wherein Plaintiff and Defendant have agreed to extend the deadline to designate experts and provide reports from retained experts. The new expert designation schedule is as follows:

Plaintiff's Experts shall be designated and reports and CVs from retained experts rendered not later than this date. 11/05/2010

Defendant's Experts shall be designated and reports and CVs from retained 12/06/2010 experts tendered not later than this date.

If this accurately reflects your understanding, please sign below and fax it back to my office.

With kind regards,

Andrew B. Sommerman

AGREED

Trek C. Degle Amorney for Defendant

Home Depot USA, Inc

EXHIBIT



JOHN F. WARREN **Dallas County Clerk** George Allen Sr. Court Bldg. 600 Commerce St, Ste 101 Dallas, Texas 75202-3551

STATE OF TEXAS

§

COUNTY OF DALLAS

I, John F. Warren, Clerk of the County Court of Dallas County Court at Law No. 1, Dallas County, Texas do hereby certify that the foregoing is a true and correct copy of document in Cause No. CC-10-01305-A.

MELVIN EVANS, PLAINTIFF (S)

VS

HOME DEPOT, U.S.A, INC, DEFENDANT (S)

PLAINTIFF'S FIRST AMENDED PETITION, REQUEST FOR DISCLOSURE, AND JURY DEMAND, FILED: SEPTEMBER 14, 2010

Minutes of County Court at Law No. 1, Dallas County, Texas.

WITNESS MY HAND AND SEAL of said Court this 5th day of October, 2010.

John F. Warren, County Clerk

ALVIN BECK, Deputy

Case 3:10-cv-02059

FLED

CAUSE NO. CC-10-01305-A

MELVIN EVANS,	§	IN THE COUNTY COURT 4 PM 3: 37
Plaintiff,	§ § §	LOWN F. WARREN COUNTY CLERK DALLAS COUNTY
VS.	§	AT LAW NO. 1
HOME DEPOT, U.S.A., INC.	§ § 8	SCANNED
Defendant.	§ §	DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST AMENDED PETITION, REQUEST FOR DISCLOSURE, AND JURY DEMAND

TO THE HONORABLE JUDGE OF SAID COURT:

COME NOW, Plaintiff Melvin Evans, and files Plaintiff's First Amended Petition, Request for Disclosure, and Jury Demand complaining of Defendant Home Depot, U.S.A., Inc., and would respectfully show unto the Court as follows:

1.00 DISCOVERY CONTROL PLAN

Pursuant to Rule 190 et seq of the Texas Rules of Civil Procedure, Plaintiff requests a Level III discovery control plan.

2.00 REQUEST FOR DISCLOSURE

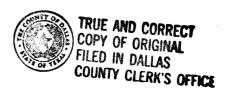
Pursuant to Rule 194 of the Texas Rules of Civil Procedure, Plaintiff requests Defendant to disclose, within fifty (50) days of service of this request, the information and material described in Rule 194.2 of the Texas Rules of Civil Procedure. Plaintiff specifically requests Defendant to produce responsive documents at the undersigned law offices within fifty (50) days of service of this request.

3.00 PARTIES

3.01—Plaintiff Melvin Evans is a resident of DeSoto, Dallas County, Texas. The last

PLAINTIFF'S FIRST AMENDED PETITION, REQUEST FOR DISCLOSURE, AND JURY DEMAND

PAGE 1



three digits of Melvin Evans' driver's license number are 433, and the last three digits of his social security number are 121.

Defendant Home Depot, U.S.A., Inc. is a foreign for-profit corporation, licensed to 3.02 do business in the State of Texas. Defendant Home Depot, U.S.A., Inc, has been served and has filed an answer.

VENUE AND JURISDICTION 4.00

This Court has venue and jurisdiction over the parties to this action since the matter 4.01 in controversy exceeds the sum or value of the minimum jurisdictional limits of the Court, exclusive of costs and interest, and because such negligence complained of herein occurred in Dallas County, Texas.

5.00 **FACTS**

- On or about May 22, 2008, at approximately 9:00 a.m., Plaintiff Melvin Evans, was 5.01 working as an employee of Defendant Home Depot, U.S.A., Inc., at the Home Depot Store #8976, under the direct supervision of Mark Bedford and Steve Thompson.
- Defendant Home Depot, U.S.A., Inc., entered into a valid and enforceable written 5.02 contract with Melvin Evans when the company hired him as an employee. For his performance as an employee, Evans was to receive compensation for medical bills incurred as a result of any workrelated injuries and compensation for any work that he would miss as a result of sustaining such injuries.
- 5.03 Plaintiff was instructed by Home Depot supervisor Mark Bedford and Steve Thompson to quickly move freight (i.e., patio furniture) from the back of the store to the front of the store in the outdoor or garden section of the store. He was moving this freight with a manual pallet jack as

instructed by these Home Depot supervisors.

- As Plaintiff pulled the manual pallet jack through the aisles of the garden or outdoor 5.04 section of the store, a cone-shaped metal sprayer, approximately 3/4" to 1" in diameter, and approximately 6" in length, which was connected to a water spigot approximately 3 feet from the ground, which was attached to a beam in the outdoor or garden section of the store, struck Plaintiff. The metal sprayer protruded into the aisle, at this height level, and was not visible to Plaintiff before it struck him.
- The metal sprayer struck Plaintiff right below his waist on the right side, directly 5.05 below his hip, causing Plaintiff to fall to the ground, resulting in the manual pallet jack striking Plaintiff in the back and left side of his body, causing serious and ongoing injuries to Plaintiff.
- 5.06 On approximately April 22, 2009, a Home Depot supervisor or supervisors, aware of Plaintiff's May 2008 incident inside Home Depot and resulting physical injuries and limitations, instructed Plaintiff to move and/or arrange lawn mowers outside of the store. Plaintiff suffered additional injuries in complying with the Home Depot supervisor's or supervisors' instructions.
- 5.07 Defendant Home Depot, U.S.A., Inc., breached its written contract with Melvin Evans because it has failed to fully compensate Melvin Evans for his medical bills and time missed from work as a result of his work-related injuries sustained on or about May 22, 2008, and April 22, 2009. These breaches of contract were unwarranted, unjustified, and without cause.

6.00 CAUSES OF ACTION AGAINST DEFENDANT HOME DEPOT, U.S.A., INC.

NEGLIGENCE

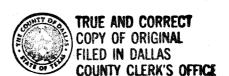
6.01 Plaintiff would also show that said Defendant breached a duty of care to Plaintiff by failing to select, hire, supervise, train or retain competent employees to maintain a safe work place

and to ensure the safety of employees like Plaintiff. The negligent acts and omissions of said Defendant were a direct and proximate cause of the incident in question and the resulting injuries and damages sustained by the Plaintiff. The violations, negligent acts, and omissions are, among others, as follows:

- a. Defendant instructed Plaintiff to move quickly through the store without regard to Plaintiff's safety;
- b. Defendant failed to warn or instruct Plaintiff of the potential hazards of moving quickly through the store;
- c. Defendant failed to properly inspect and/or maintain the store against potential hazards to its employees;
- d. Defendant failed to properly and safely supervise the moving of the pallets or freight.
- e. Defendant failed to adequately train, educate, and instruct its employees and/or staff to maintain a safe workplace and to protect the health and safety of its employees;
- f. Defendant retained its employees and/or staff knowing that they were performing their duties and obligations in an unsafe manner;
- g. Defendant failed to inspect and/or maintain the premises in a safe condition; and
- h. Defendant created a dangerous condition and failed to warn Plaintiff of the dangerous condition.
- 6.02 On the occasion in question, Mark Bedford and Steve Thompson, as well as any other supervisor of Plaintiff, were acting as supervisors employed by Home Depot, U.S.A., Inc., to supervise Plaintiff and his coworkers, in the furtherance of the business of Home Depot, U.S.A., Inc.; therefore, Plaintiff asserts causes of action against Home Depot, U.S.A., Inc., based on the theory of *Respondeat Superior*.

BREACH OF CONTRACT

6.03 Defendant Home Depot, U.S.A., Inc., entered into a valid and enforceable written



contract when it contracted with Plaintiff Melvin Evans. In exchange for Evan's performance as an employee, Evans was to receive compensation from Defendant for medical bills incurred as a result of any work-related injuries and compensation for any work that he would miss as a result of sustaining such injuries.

- Plaintiff Melvin Evans performed by, among other things, working his assigned shifts at the Home Depot store where he was assigned to work.
- Defendant Home Depot, U.S.A., Inc., breached its contract with Plaintiff Melvin 6.05 Evans by failing to meet its obligations described above when Melvin Evans sustained work-related injuries on or about May 22, 2008, and April 22, 2009after Melvin Evans had performed his end of the contract.

7.00 DAMAGES

- As a direct and proximate result of the negligence described above, Plaintiff has 7.01 suffered the following damages:
- As a result of the incident described herein, Plaintiff has incurred medical expenses 7.02 and in all reasonable probability such medical expenses will continue in the future.
- Plaintiff has suffered lost wages and/or lost earning capacity in the past as a result of 7.03 this incident and in reasonable probability such lost earning capacity will continue in the future.
- Plaintiff has experienced physical pain and suffering in the past as a result of this 7.04 incident and in all reasonable probability will sustain physical pain and suffering in the future as a result of his physical injuries.
- Plaintiff has experienced mental anguish in the past as a result of this incident and 7.05 in all reasonable probability will sustain mental anguish in the future as a result of this incident.

- Plaintiff has experienced physical impairment or physical incapacity in the past as a 7.06 result of this incident and in reasonable probability will sustain physical impairment or physical incapacity in the future.
- Plaintiff has experienced physical disfigurement in the past and in all reasonable 7.07 probability will suffer physical disfigurement in the future as a result of the incident in question.
- As a result of the above, Plaintiff seek damages in excess of the minimum 7.08 iurisdictional limits of this Court.

8.00 **EXEMPLARY DAMAGES**

For additional causes of action, Plaintiff re-pleads as fully as though set forth in this paragraph all allegations under paragraphs 1.00 through 7.00 and alleges that all the acts and omissions on the part of the Defendant, taken singularly or in combination, constitute gross negligence and were the proximate cause of the damages and injuries of Plaintiff as alleged herein. This gross negligence entitles the Plaintiff to exemplary damages. Specifically, Plaintiff alleges that the Defendant's acts were more than momentary thoughtlessness, inadvertence, or error of judgment. The Defendant acted with such an entire want of care to establish that the acts and/or omissions were the result of actual conscious indifference to the rights, safety or welfare of the Plaintiff. Plaintiff seeks exemplary damages against the Defendant in the amount of four times Plaintiff's actual damages or to punish Defendant for its wrongdoing and to deter other companies that might be tempted to engage in the same or similar conduct.

9.00 CLAIM FOR PRE-JUDGMENT AND POST-JUDGMENT INTEREST

Plaintiff claims all lawful pre-judgment and post-judgment interest on the damages suffered by him.

10.00 JURY DEMAND

Plaintiff requests that a jury be convened to try the factual issues in this cause.

WHEREFORE, PREMISES CONSIDERED, Plaintiff prays that Defendant be cited to appear and answer herein and, upon final hearing of this cause, Plaintiff have judgment against Defendant for damages described herein, for costs of suit, interest from the date of the incident and for such other and further relief to which Plaintiff may be justly entitled.

Respectfully submitted,

SOMMERMAN & QUESADA, L.L.P.

Andrew B. Sommerman

State Bar No. 18842150

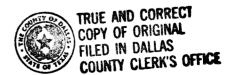
3811 Turtle Creek Boulevard, Suite 1400

Dallas, Texas 75219

214/720-0720 (Telephone)

214/720-0184 (Facsimile)

ATTORNEYS FOR PLAINTIFFS



CERTIFICATE OF SERVICE

I hereby certify by my signature above that a true and correct copy of the foregoing instrument has been sent to all attorneys of record in the above-styled and numbered matter, said service being effected in the following manner this \(\frac{14^{10}}{2} \) day of September, 2010:

Certified Mail/Return Receipt Requested	
Hand Delivery	
Telecopy	<u>×</u>
Regular Mail	
E-Mail	



SOM MERM: A CV & 2059 BD A DOCUMENT IPI Filed 10/13/10

381† TURTLE CREEK BOULEVARD, SUITE 1400 DALLAS, TEXAS 75219
TELEPHONE 214-720-0720
TOLL FREE 800-900-5373
TELECOPIER 214-720-0184
personaliniury@textrial.com

Page 69 of 81 Page 1 149
ANDREWS SOMMERMAN †
GEORGE (TEX) QUESADA ††
HEATHER LONG ††N

2011 SED 11 MWW.textrial.com MARY ALIOE MICLARTY 111 Of Counsel

Of Counsel

Board Certified in Personal Injury Trial Law
Board Certified in Civil Trial Law
Certified Civil Trial Advocate:
National Board of Trial Fovocacy
† College of the State Bar of Texas
† Licensed in Texas and New Mexico
†† Licensed in Texas and District of Columbia

September 14, 2010

Clerk
County Court at Law No. 1
George L. Allen, Sr. Courts Building
600 Commerce Street, 5th Floor
Dallas, Texas 75202-4606

Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of Plaintiff's First Amended Petition, Request for Disclosure and Jury Demand. Please file this document and return a file-marked copy to the courier.

By copy of this letter, all counsel are being served with a copy of this pleading.

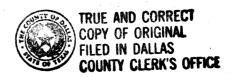
Thank you for your assistance in this matter.

Deanna Inman

Legal Assistant

cc:

VIA FAX 512/370-2850 Trek C. Doyle Winstead PC 401 Congress Ave., Suite 2100 Austin, TX 78701







JOHN F. WARREN **Dallas County Clerk** George Allen Sr. Court Bldg. 600 Commerce St, Ste 101 Dallas, Texas 75202-3551

STATE OF TEXAS

§

COUNTY OF DALLAS

I, John F. Warren, Clerk of the County Court of Dallas County Court at Law No. 1, Dallas County, Texas do hereby certify that the foregoing is a true and correct copy of document in Cause No. CC-10-01305-A.

MELVIN EVANS, PLAINTIFF (S)

VS

HOME DEPOT, U.S.A, INC, DEFENDANT (S)

PLAINTIFF'S FIRST SUPPLEMENTAL PETITION, **REQUEST FOR** DISCLOSURE, AND JURY DEMAND, FILED: SEPTEMBER 17, 2010 Minutes of County Court at Law No. 1, Dallas County, Texas.

WITNESS MY HAND AND SEAL of said Court this 5th day of October, 2010.

John F. Warren, County Clerk

ALVIN BECK, Deputy





CAUSE NO. CC-10-01305-A

FILED

MELVIN EVANS,	§ IN THE COMPREPAGUEN	
Plaintiff,	\$ \$ \$	JOHN F. WARREN COUNTY CLERK
VS.	§	AT LAW NODALLAS COUNTY
HOME DEPOT, U.S.A., INC.	§ §	
Defendant.	8 8	DALLAS COUNTY, TEXAS

PLAINTIFF'S FIRST SUPPLEMENTAL PETITION, REQUEST FOR DISCLOSURE, AND JURY DEMAND SCANNED

TO THE HONORABLE JUDGE OF SAID COURT:

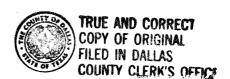
COME NOW, Plaintiff Melvin Evans, and files Plaintiff's First Supplemental Petition, Request for Disclosure, and Jury Demand complaining of Defendant Home Depot, U.S.A., Inc., and would respectfully show unto the Court as follows:

1.00 DISCOVERY CONTROL PLAN

Pursuant to Rule 190 et seq of the Texas Rules of Civil Procedure, Plaintiff requests a Level III discovery control plan.

2.00 REQUEST FOR DISCLOSURE

Pursuant to Rule 194 of the Texas Rules of Civil Procedure, Plaintiff requests Defendant to disclose, within fifty (50) days of service of this request, the information and material described in Rule 194.2 of the Texas Rules of Civil Procedure. Plaintiff specifically requests Defendant to produce responsive documents at the undersigned law offices within fifty (50) days of service of this request.



3.00 **PARTIES**

- Plaintiff Melvin Evans is a resident of DeSoto, Dallas County, Texas. The last 3.01 three digits of Melvin Evans' driver's license number are 433, and the last three digits of his social security number are 121.
- Defendant Home Depot, U.S.A., Inc. is a foreign for-profit corporation, licensed to 3.02 do business in the State of Texas. Defendant Home Depot, U.S.A., Inc, has been served and has filed an answer.

4.00 VENUE AND JURISDICTION

This Court has venue and jurisdiction over the parties to this action since the matter 4.01 in controversy exceeds the sum or value of the minimum jurisdictional limits of the Court, exclusive of costs and interest, and because such negligence complained of herein occurred in Dallas County, Texas.

5.00 **FACTS**

- On or about May 22, 2008, at approximately 9:00 a.m., Plaintiff Melvin Evans, was 5.01 working as an employee of Defendant Home Depot, U.S.A., Inc., at the Home Depot Store #8976, under the direct supervision of Mark Bedford and Steve Thompson.
- Defendant Home Depot, U.S.A., Inc., entered into a valid and enforceable written 5.02 contract with Melvin Evans when the company hired him as an employee. For his performance as an employee, Evans was to receive compensation for medical bills incurred as a result of any workrelated injuries and compensation for any work that he would miss as a result of sustaining such injuries.
 - 5.03 Plaintiff was instructed by Home Depot supervisor Mark Bedford and Steve Thompson

to quickly move freight (i.e., patio furniture) from the back of the store to the front of the store in the outdoor or garden section of the store. He was moving this freight with a manual pallet jack as instructed by these Home Depot supervisors.

- As Plaintiff pulled the manual pallet jack through the aisles of the garden or outdoor 5.04 section of the store, a cone-shaped metal sprayer, approximately 3/4" to 1" in diameter, and approximately 6" in length, which was connected to a water spigot approximately 3 feet from the ground, which was attached to a beam in the outdoor or garden section of the store, struck Plaintiff. The metal sprayer protruded into the aisle, at this height level, and was not visible to Plaintiff before it struck him.
- The metal sprayer struck Plaintiff right below his waist on the right side, directly 5.05 below his hip, causing Plaintiff to fall to the ground, resulting in the manual pallet jack striking Plaintiff in the back and left side of his body, causing serious and ongoing injuries to Plaintiff.
- On approximately April 22, 2009, a Home Depot supervisor or supervisors, aware 5.06 of Plaintiff's May 2008 incident inside Home Depot and resulting physical injuries and limitations, instructed Plaintiff to move and/or arrange lawn mowers outside of the store. Plaintiff suffered additional injuries in complying with the Home Depot supervisor's or supervisors' instructions.
- 5.07 Defendant Home Depot, U.S.A., Inc., breached its written contract with Melvin Evans because it has failed to fully compensate Melvin Evans for his medical bills and time missed from work as a result of his work-related injuries sustained on or about May 22, 2008, and April 22, 2009. These breaches of contract were unwarranted, unjustified, and without cause.

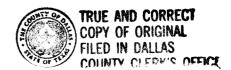
6.00 CAUSES OF ACTION AGAINST DEFENDANT HOME DEPOT, U.S.A., INC.

NEGLIGENCE

- 6.01 Plaintiff would also show that said Defendant breached a duty of care to Plaintiff by failing to select, hire, supervise, train or retain competent employees to maintain a safe work place and to ensure the safety of employees like Plaintiff. The negligent acts and omissions of said Defendant were a direct and proximate cause of the incident in question and the resulting injuries and damages sustained by the Plaintiff. The violations, negligent acts, and omissions are, among others, as follows:
 - a. Defendant instructed Plaintiff to move quickly through the store without regard to Plaintiff's safety;
 - b. Defendant failed to warn or instruct Plaintiff of the potential hazards of moving quickly through the store;
 - c. Defendant failed to properly inspect and/or maintain the store against potential hazards to its employees;
 - d. Defendant failed to properly and safely supervise the moving of the pallets or freight.
 - e. Defendant failed to adequately train, educate, and instruct its employees and/or staff to maintain a safe workplace and to protect the health and safety of its employees;
 - f. Defendant retained its employees and/or staff knowing that they were performing their duties and obligations in an unsafe manner;
 - g. Defendant failed to inspect and/or maintain the premises in a safe condition; and
 - h. Defendant created a dangerous condition and failed to warn Plaintiff of the dangerous condition.
- 6.02 On the occasion in question, Mark Bedford and Steve Thompson, as well as any other supervisor of Plaintiff, were acting as supervisors employed by Home Depot, U.S.A., Inc., to supervise Plaintiff and his coworkers, in the furtherance of the business of Home Depot, U.S.A., Inc.;

PLAINTIFF'S FIRST SUPPLEMENTAL PETITION, REQUEST FOR DISCLOSURE, AND JURY DEMAND

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therefore, Plaintiff asserts causes of action against Home Depot, U.S.A., Inc., based on the theory of Respondeat Superior.

BREACH OF CONTRACT

- Defendant Home Depot, U.S.A., Inc., entered into a valid and enforceable written 6.03 contract when it contracted with Plaintiff Melvin Evans. In exchange for Evan's performance as an employee, Evans was to receive compensation from Defendant for medical bills incurred as a result of any work-related injuries and compensation for any work that he would miss as a result of sustaining such injuries.
- 6.04 Plaintiff Melvin Evans performed by, among other things, working his assigned shifts at the Home Depot store where he was assigned to work.
- Defendant Home Depot, U.S.A., Inc., breached its contract with Plaintiff Melvin 6.05 Evans by failing to meet its obligations described above when Melvin Evans sustained work-related injuries on or about May 22, 2008, and April 22, 2009after Melvin Evans had performed his end of the contract.
- The Defendant's breach of contract was, singularly and severally, a proximate cause 6.06 of Plaintiff's injuries.

7.00 **DAMAGES**

- As a direct and proximate result of the negligence described above, Plaintiff has suffered the following damages:
- As a result of the incident described herein, Plaintiff has incurred medical expenses 7.02 and in all reasonable probability such medical expenses will continue in the future.
 - Plaintiff has suffered lost wages and/or lost earning capacity in the past as a result of 7.03

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this incident and in reasonable probability such lost earning capacity will continue in the future.

- Plaintiff has experienced physical pain and suffering in the past as a result of this 7.04 incident and in all reasonable probability will sustain physical pain and suffering in the future as a result of his physical injuries.
- Plaintiff has experienced mental anguish in the past as a result of this incident and 7.05 in all reasonable probability will sustain mental anguish in the future as a result of this incident.
- Plaintiff has experienced physical impairment or physical incapacity in the past as a 7.06 result of this incident and in reasonable probability will sustain physical impairment or physical incapacity in the future.
- Plaintiff has experienced physical disfigurement in the past and in all reasonable 7.07 probability will suffer physical disfigurement in the future as a result of the incident in question.
- As a result of the above-mentioned actions and/or omissions by Defendant Home 7.08 Depot, U.S.A., Inc., Melvin Evans suffered monetary damages. These damages were natural, probable, and a foreseeable consequence of the defendant's breach of contract and other actions that Melvin Evans detrimentally relied upon. Specifically, Melvin Evans suffered damages in the form of lost salary and medical bills that he paid or incurred a debt from as a result of his work-related injury.
- As a result of the above, Plaintiff seek damages in excess of the minimum 7.09 jurisdictional limits of this Court.

EXEMPLARY DAMAGES 8.00

For additional causes of action, Plaintiff re-pleads as fully as though set forth in this paragraph all allegations under paragraphs 1.00 through 7.00 and alleges that all the acts and

omissions on the part of the Defendant, taken singularly or in combination, constitute gross negligence and were the proximate cause of the damages and injuries of Plaintiff as alleged herein. This gross negligence entitles the Plaintiff to exemplary damages. Specifically, Plaintiff alleges that the Defendant's acts were more than momentary thoughtlessness, inadvertence, or error of judgment. The Defendant acted with such an entire want of care to establish that the acts and/or omissions were the result of actual conscious indifference to the rights, safety or welfare of the Plaintiff. Plaintiff seeks exemplary damages against the Defendant in the amount of four times Plaintiff's actual damages or to punish Defendant for its wrongdoing and to deter other companies that might be tempted to engage in the same or similar conduct.

9.00 ATTORNEYS' FEES

Plaintiff requests that he be granted relief in the form of attorney fees from Defendant 9.01 Home Depot, U.S.A., Inc., pursuant to TEX. CIV. PRAC. & REM. CODE section 38.001(8).

10.00 CLAIM FOR PRE-JUDGMENT AND POST-JUDGMENT INTEREST

Plaintiff claims all lawful pre-judgment and post-judgment interest on the damages suffered by him.

11.00 JURY DEMAND

Plaintiff requests that a jury be convened to try the factual issues in this cause.

WHEREFORE, PREMISES CONSIDERED, Plaintiff prays that Defendant be cited to appear and answer herein and, upon final hearing of this cause, Plaintiff have judgment against Defendant for damages described herein, for costs of suit, interest from the date of the incident and for such other and further relief to which Plaintiff may be justly entitled.

Respectfully submitted,

SOMMERMAN & QUESADA, L.L.P.

Andrew B. Sommerman State Bar No. 18842150

3811 Turtle Creek Boulevard, Suite 1400

Dallas, Texas 75219

214/720-0720 (Telephone)

214/720-0184 (Facsimile)

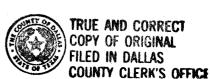
ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify by my signature above that a true and correct copy of the foregoing instrument has been sent to all attorneys of record in the above-styled and numbered matter, said service being effected in the following manner this 17 day of September, 2010:

Certified Mail/Return Receipt Requested	X
Hand Delivery	, <u></u>
Telecopy	
Regular Mail	·
E-Mail	

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Licensed in Texas and New Mexico ††† Licensed in Texas and District of Columbia

September 17, 2010

Clerk County Court at Law No. 1 George L. Allen, Sr. Courts Building 600 Commerce Street, 5th Floor Dallas, Texas 75202-4606

> Re: Cause No. CC-10-01305-A; Melvin Evans v. Home Depot, USA, Inc.

Dear Clerk:

Enclosed for filing among the papers of this Court are an original and one copy of Plaintiff's First Supplemental Petition, Request for Disclosure and Jury Demand. Please file this document and return a file-marked copy to the courier.

By copy of this letter, all counsel are being served with a copy of this pleading.

Thank you for your assistance in this matter.

Legal Assistant

cc:

VIA FAX 512/370-2850 Trek C. Doyle Winstead PC 401 Congress Ave., Suite 2100 Austin, TX 78701

